Health Care Financing Administration

Marketing Resource Manual for EPSDT Provider Recruitment

Information Resource Center

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M A R K E T I N G R E S O U R C E G U I D E

FOR

RECRUITMENT AND RETENTION

OF PROVIDERS IN THE

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM (EPSDT)

June, 1982

Based on Materials Developed by Community Health Foundation
Under Contract Number HCFA-500-80-0082
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Bureau of Program Operations, Health Care Financing Administration
U. S. Department of Health and Human Services

FOREWORD

Within Medicaid, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program uniquely requires States to seek out eligible persons under 21, inform them and their families about the benefits and availability of preventive health services and, if requested, to assess their health problems and ensure that problems are brought under care. Maintaining an efficient base, or network, of participating physicians, dentists and other health providers is essential for a State to meet its child health program responsibilities.

This "Marketing Resource Guide" was prepared to help State and local agencies deal with issues inherent in enlisting adequate provider support and stemming attrition among participating providers. Materials were developed by the Community Health Foundation (CHF) under a contract with the Health Care Financing Administration, (HCFA 500-80-0082), to design and test improved methods of provider recruitment and retention.

At the outset, a literature review was conducted, to learn those lessons which could be drawn from previous EPSDT experiences and from other private and public sector programs and organizations. CHF then applied and assessed a systematic marketing approach, to aid the State of Massachusetts in an enhanced provider recruitment effort.

Thus, the Guide reflects the participation of various provider groups in a collaborative effort sponsored by the Massachusetts Department of Public Welfare. Certain EPSDT implementation problems are detailed from their perspective. Further, the Guide describes a marketing approach and plan for provider recruitment and retention, and provides a training package to be used by both State and local staff.

Throughout, the guide refers to "Project Good Health" (PGH), the name of the Massachusetts EPSDT program, because that is the site where the approach was applied and tested. Nevertheless, the information and the methods can be used by all States seeking to improve provider recruitment and participation. A special word of thanks must go to those members of the Project Good Health staff in the Massachusetts Department of Public Welfare who participated so actively and gave their support and expertise so generously to this project. Such local-State-Federal collaboration is essential to the successful implementation of a comprehensive health program in behalf of Medicaid-eligible children.

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A. INTRODUCTION

A.1. Purpose of the Contract

The purpose of this contract is to develop a marketing plan to recruit physicians to participate in EPSDT.

A.2. Purpose of the General Methodology

The general methodology outlined in this report is based on the findings of the Literature Review and Data Analysis which CHF conducted during the first phase of the contract. The methodology CHF proposes is specific to the needs of the Massachusetts EPSDT program, Project Good Health (PGH). Nevertheless, the methodology applies the principles of marketing to the general problem of recruiting physicians to provide secondary prevention services to low income individuals under 21 years old, the costs for which are to be paid by the state's EPSDT/Medicaid program. As such, the methodology will be relevant to other states' EPSDT programs as well. Moreover, the marekting principles outlined here can apply to any situation of encouraging a defined population to adopt a particular behavior vis-a-vis a particular product or service. In this context, this methodology can be adapted easily to satisfy the marketing needs of other public agencies.

A.3. What is Marketing?

Marketing is the task of finding and securing consumers for a firm's output. Through marketing, a firm develops an understanding of consumers' needs. This understanding enables the firm to offer services or products consistent with these needs. In contrast to private firms, public agencies and social service organizations market a "program" rather than a "product." However, the principles of marketing are no less applicable: public agencies, like private firms, must find, secure and retain consumers. For this contract, CHF has identified the physician as the consumer to whom PGH is trying to market a product, the PGH program.

To be successful, a marketing program must also include the elements of sound planning. The program must define, accomplish and evaluate objectives, rather than simply prescribe an advertising or sales campaign. This methodology includes such a planning approach.

B. A MARKETING APPROACH

In the past, most state EPSDT programs, Massachusetts included, have approached physicians as an homogeneous mass. For example, if states have program information to disseminate, they send a single message to everyone. Usually states send a letter to physicians, or arrange a meeting or series of meetings with a single agenda. This approach does not recognize the characteristics which may distinguish one group of physicians from another. There are many possible groupings, such as geographic location, current Medicaid participation status, type of practice, specialty, and academic affiliation.

A sound marketing approach will first identify the various groupings, or market segments which are relevant to the objectives to be achieved. CHF's findings from reviewing the literature on provider recruitment, analyzing provider data, and interviewing providers and provider organization representatives in Massachusetts support such an approach. Indeed, CHF found that geographic location and Medicaid participation status are two criteria which are especially critical in recruiting more physicians for PGH.

Secondly, since there are only limited resources available to convince physicians to participate, the state must concentrate these resources to maximize the desired effect--physician participation. Marketing experts advise us that the most efficient approach utilizes diffusion theory. Diffusion theory suggests that some segments and some members of each segment will be quicker to adopt innovation and change than others.

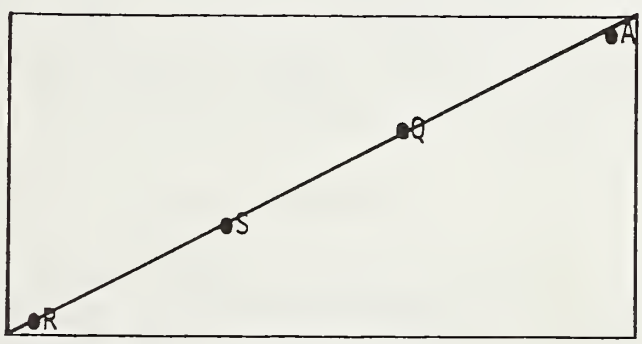
Organizations can use their marketing resources most efficiently by first targeting the easiest to change. By focussing on a single market segment, or sub-segment, the state can concentrate its resources efficiently and effectively and demonstrate successes in a shorter period of time and at less cost than by marketing to all segments at once. The first successes initiate the diffusion process. Building on successes is a basic tenent of marketing and is especially relevant to state agencies with limited resources at their disposal for marketing EPSDT.

Third, once target segments are identified, the next objective is to convince members of the segments to purchase PGH. There are four (4) stages to the purchasing process. These stages are:

- Awareness
- Qualification
- Selection, and
- Retention.

The chart below depicts the relative amount of personal versus non-personal contact associated with stages of the process.

- Awareness
- Qualification
- Selection
- Retention



100% Non-Personal

100% Personal

As the chart shows, each stage of AQSR requires somewhat different techniques.

Awareness can be accomplished by non-personal techniques. Letters, invitations, display advertising, posters, etc. are all effective tools for creating awareness of a product.

Qualification requires more specialized information for the individuals who comprise the market to determine if they qualify, i.e., if the product is "for them."

Selection requires the individual to make a decision to "select," or purchase the product. This requires personalized information, often in the form of a personal selling campaign.

Retention, is crucial to a marketing plan, but often overlooked by government agencies. Retention activities are the most cost effective because they have the highest marginal value. It is generally much less difficult and expensive to keep persons interested than it is to convince them to participate in the first place. Since each person already participating has had a unique experience with the program, a personal approach is necessary. Nevertheless, there are some non-personal activities which can be undertaken for this component as well. A newsletter or periodic report on program accomplishments are two examples of non-personal techniques appropriate for the retention stage.

Supervisors can also use the AQSR approach to help determine assignments for their marketing personnel. For example, calling or visiting a participating physician to inquire about problems and say a few words of encouragement and appreciation is considerably different than trying to sell the program to a non-participating physician. The latter task will require more concentrated selling skills, more facts, training and technical competence.

Using the approach discussed above, CHF proposes a seven-part marketing plan to recruit physicians for PGH.

B.1. Marketing Plan

- Identify Potential Market

The first objective is to identify the potential pool of providers who can deliver PGH services. This group is the "market." Since PGH services are basically secondary prevention services, the market is primarily composed of physicians who provide primary care. These physicians include pediatricians, internists, family practitioners, and obstetrician-gynecologists. As Chart I shows, there are 2,388 primary care physicians in Massachusetts. This total represents about seventeen percent (17%) of all the physicians in the state.

- Identify Market Segments

Identifying market segments is imperative because there are too many physicians located in diverse areas, practicing in different practice settings and serving different population groups for it to be likely that a single marketing approach would succeed in changing the behavior of all such groups. There are a number of different ways of defining the market segments. The market can be segmented by practice location (city, region); practice type (solo, group, pre-paid health plan, community health center); practice specialty (general practice, pediatrics); patient income (low, middle high); and current or prior participation in PGH and/or Medicaid.

The Literature Review identifies each of these as relevant indicators of the likelihood of physician participation in Project Good Health. However, based on the Data Analysis and further study of the PGH program, CHF recommends that Massachusetts identify the following specific segments for the purpose of developing marketing programs:

Segment A. Physicians participating in Project Good Health as of June 30, 1981.

Segment B. Primary care physicians currently participating in the Massachusetts Medicaid program, but not in PGH as of June 30, 1981.

Segment C. Primary care physicians not participating in Medicaid or PGH, practicing in towns with an insufficient number of physicians providing primary care to Medicaid clients, and

Segment D. Community Health Centers.

These segments are defined in greater detail on page 7.

- Target the Market Segments

Marketing principles can be used to achieve the most efficient use of the state's resources. This objective can be achieved by targeting specific segments. Specific approaches to recruitment will be developed for each of the target segments. Targets are selected based on the likelihood of the success (successful recruitment to PGH) and the impact successful recruitment would have on the overall goal of recruiting sufficient number of providers. While certain segments may meet some criteria and not others, the targets should be selected so that together they provide the best chances of success and most efficient use of the state's limited resources.

- Develop a Marketing Program for Each Targeted Segment

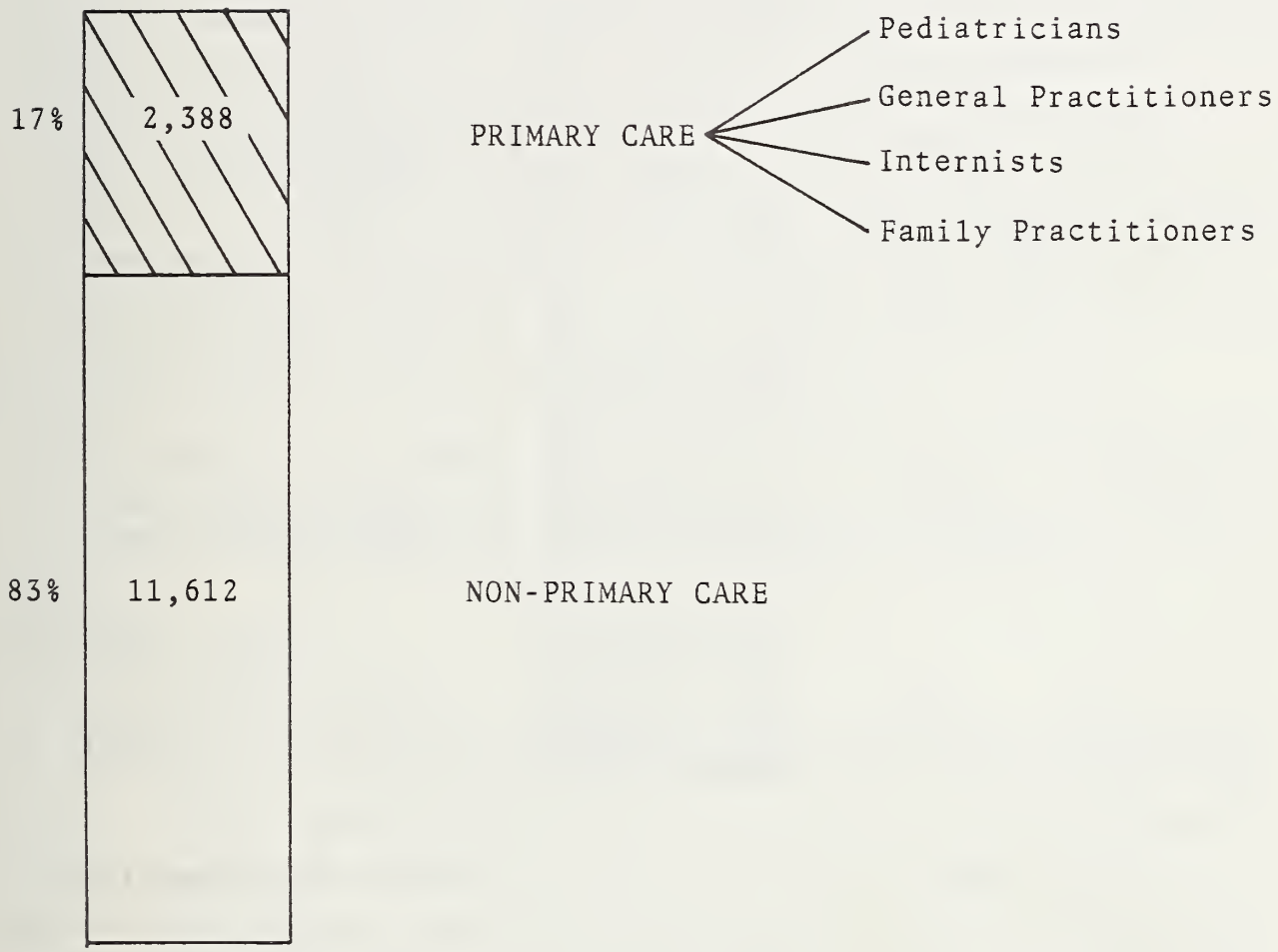
These programs will entail the collection and anaylsis of both qualitative and quantitative data. Qualitative data will provide insight into physicians' perceived problems and understanding of the PGH program. These data can be collected by convening "focus panels" (groups of 6 - 15 physicians) in one or two of the communities; and by conducting interviews and conversations with key physicians in these communities. Quantitative data will be used to determine whether or not the impressions obtained in the focus panels are accurate. CHF will test the qualitative information obtained from the focus panels by conducting a random mail survey to validate and to refine the findings from the focus panels.

- Test, Evaluate and Reconfigure Marketing Programs

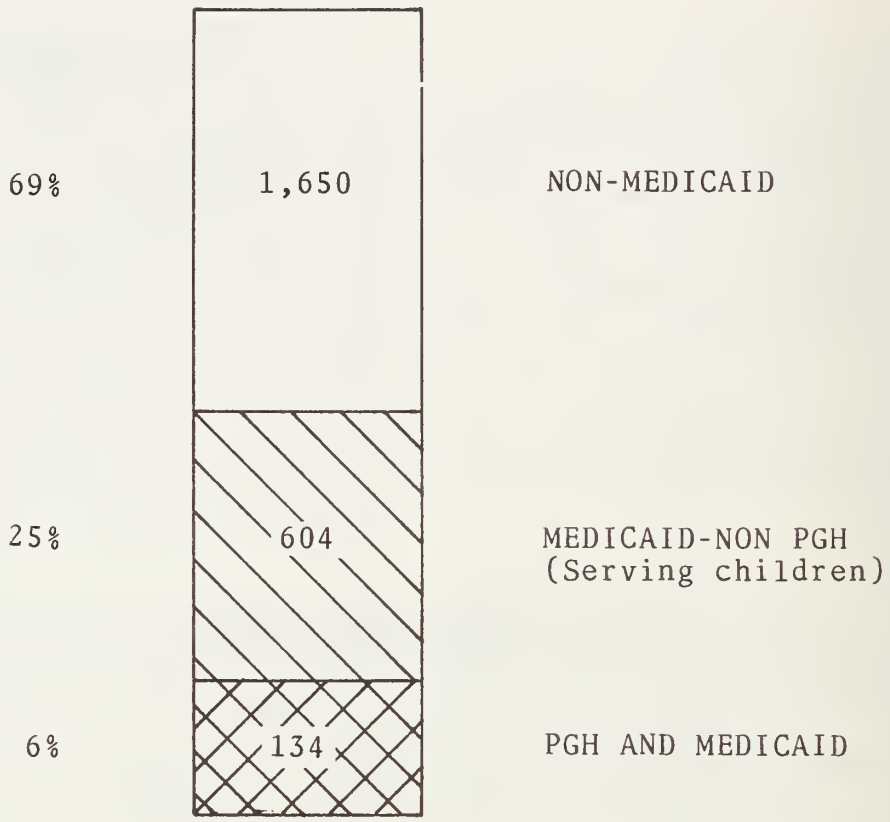
- Design and Recommend a Continuing Plan for Implementation and Evaluation of the Marketing Programs

CHART I

14,000 PHYSICIANS IN MASSACHUSETTS



2,388 PRIMARY CARE PHYSICIANS



- Prepare a Training Manual and Train State PGH Staff to Implement and Evaluate the Marketing Programs

Once developed, the marketing programs will be tested, evaluated and reconfigured based on test results. CHF will train designated Project Good Health staff to conduct the marketing programs.

Each marketing strategy will include provisions to maintain providers participation and interest in PGH. Once physicians have been recruited, the most efficient use of state resources is to maintain physician's interest in the PGH program. While many physicians initially agree to provide services, many eventually drop out. There are many reasons for physicians to drop out. One recurring theme is that physicians experience problems with PGH and have no one in the state to turn to with questions. The physicians' interest in participating is not reinforced by any direct communication with the state regarding program issues.

In summary, a key component to marketing is maintaining one's client base, in this case the physicians who have agreed to participate. Retention activities are essential to achieving the program's objectives.

B.2. Market Segments

Segment A. Physicians participating in Project Good Health as of June 30, 1981. This market segment can be classified for Retention according to the AQSR paradigm. There are 134 physicians who were registered as Project Good Health Providers as of June 30, 1981. (Chart II) The state has already contacted these physicians once during May and June, 1981. In the section that follows, CHF will outline the work-steps needed to design a retention program for this segment.

Segment B. Primary Care - Physicians currently participating in the Massachusetts Medicaid program, but not in Group A. There are 604 physicians in this category. (Chart II). In mid-May, CHF developed a Qualification and Selection program for physicians in this segment. CHF conducted a workshop for provider recruitment staff on how to conduct a personal selling campaign which is part of the Qualification and Selection program. In the workstep section which follows, CHF describes all the steps which are needed to recruit this segment.

Segment C. Primary Care Physicians who do not participate in Medicaid or PGH currently and who practice in towns with an insufficient number of physicians who provide primary care under Medicaid. In analyzing the Massachusetts provider data, CHF estimates that there are a sufficient number of physicians who currently participate in Medicaid to serve the Medicaid eligible population under 21 years of age in all regions of the state. Because of the paucity of data concerning interregional migration of clients to physicians offices, CHF cannot be town-specific in its targeting. However, CHF proposes that the Springfield and Lawrence regions have relatively low number of primary care physicians already participating in Medicaid. Because of this these two regions should be targeted for the recruitment of physicians who are not participating in Medicaid. This segment will require Awareness as well as Qualification and Selection programs. CHF will describe the steps needed to accomplish this in the workstep section below.

Segment D. Community Health Centers. Massachusetts has the most extensive community health center network in the country. Most of the health centers serve predominantly low-income and Medicaid-eligible families. The centers are established to provide quality, comprehensive health services to low income people in need of government support. All these health centers already provide Medicaid services and many have been providing Project Good Health or its equivalent to the Medicaid eligible population under 21. Community health centers are an ideal resource for Project Good Health. Recognizing their potential to serve PGH eligibles, the state adopted changes in Project Good Health which were designed, in part, to provide incentives for community health centers to Project Good Health services. Community Health Centers now receive a financial incentive, in the form of $5.50 more than the current Medicaid reimbursement rate, if they participate in Project Good Health.

The contacts Community Health Foundation has made with individual community health centers and with the Massachusetts League of Community Health Centers indicate that there is considerable interest and willingness to provide Project Good Health services.

SUMMARY OF THE CHF/PGH PHYSICIAN MARKETING PROGRAM

MAJOR OBJECTIVES:

The Marketing Plan consists of the following major objectives.

- To identify potential PGH physicians based on medical specialty, geographic location and previous participation in PGH and Medicaid.
- To identify geographic areas of greatest need for PGH services.
- To develop market segments.
- To select target segments for marketing.
- To develop marketing programs:
  - To encourage physicians to participate initially in PGH.
  - To encourage participating physicians to serve more PGH-eligible children, and
  - To maintain physician participation over time.
- To test, evaluate, and reconfigure marketing programs.
- To design and recommend a continuing plan for implementation and evaluation of the marketing programs.
- To prepare a training manual and train state PGH staff to implement and evaluate the Marketing Programs.

The major objectives presented above are outlined in more detail in the Worksteps below. The Worksteps are clustered around the four Market Segments.

WORKSTEPS/ACTIVITIES

The following are the Worksteps for marketing programs for the four physician target segments.
The charts below identify each Workstep and the organization (CHF, PGH or both) responsible for completing the Workstep. Dates for completion of every workstep are not provided. Since responsibility for completing many worksteps lies with the state PGH program, the dates must still be negotiated. However, dates have been provided for those Worksteps initiated to date (February, 1982). Worksteps completed prior to the end of the contract are marked with an asterisk (*).

PGH MARKETING PROGRAM
WORKSTEPS

SEGMENT A: Primary Care Physicians participating in Project Good Health as of July 30, 1981

GOAL: To develop, implement and evaluate a Retention Program for PGH contract physicians.

NUMBER	WORKSTEP DESCRIPTION	ORGANIZATION RESPONSIBLE FOR COMPLETION
*A.1.	Interview PGH staff who personally contacted PGH physicians in recruitment effort conducted in April-May, 1981. (May 1981)	CHF
*A.2.	Develop a research instrument for PGH to determine the need and interests of physicians who are already participating in Project Good Health.	CHF
A.3.	Survey physicians to determine the amount and nature of contact they prefer to have with PGH field staff and central office personnel.	PGH/CHF
A.4.	Analyze results of survey and interview selected physicians in more detail if necessary.	PGH
A.5.	Develop procedures and protocols for field staff to follow in conducting recruitment efforts.	CHF/PGH
*A.6	Train PGH field staff on importance, value and skills necessary to conduct a retention program.	CHF
A.7.	Test various protocols and procedures in different regions in the state.	CHF
A.8.	Evaluate the tests by measuring the changes in physician participation and by comparing their participation with control groups.	PGH
A.9.	Restructure the retention program and restrain state PGH field staff based on the results of the evaluation.	PGH
A.10.	Organize provider advisory group to discuss program problems and changes periodically, and use groups as another medium to communicate with local physicians.	PGH

PGH MARKETING PROGRAM
WORKSTEPS

SEGMENT B: Primary care physicians who provide services to children under 21 years of age under the Massachusetts Medicaid program.

GOAL: To develop, implement and evaluate a PGH recruitment program for Segment B physicians.

NUMBER	WORKSTEP DESCRIPTION	ORGANIZATION RESPONSIBLE FOR COMPLETION
*B.1.	Interview physicians who have provided services to children under 21 through Medicaid. The purposes of this are (1) to identify their perception of Project Good Health's strengths and weaknesses relative to Medicaid and (2) to estimate their current level of awareness of Project Good Health and the changes that occurred in the program recently. (May-August 1981)	PGH
*B.2.	Identify towns with both high numbers of Medicaid eligible children and providers in those cities who have provided a large number of services through Medicaid. (May 1981)	CHF
*B.3.	Develop Qualification and Selection program. This will emphasize a personal selling campaign to recruit physicians in the communities identified. (May 1981)	CHF
*B.4.	Train PGH staff to conduct the personal selling campaign. Because of the state's immediate need to begin recruitment CHF developed and conducted this training program during May 1981. The training program included didactic and experiential components. The purpose was to prepare PGH personnel who had different levels of familiarity and interest in the program themselves to be effective sales people in the field. CHF training included lessons on identifying the providers, arranging an appointment, appropriate openings, content of materials covered during the meetings, appropriate closings and alternative responses depending on physician interest in the program. (May 1981)	CHF
*B.5.	Conduct personal selling programs. (June-August)	PGH
*B.6.	Evaluate results of central office staff efforts in B.5. (November-December 1981)	CHF
B.7.	Restructure program based on results of test.	PGH
B.8.	Retrain staff accordingly including field based PGH staff if necessary.	PGH

PGH MARKETING PROGRAM
WORKSTEPS

SEGMENT C: Physicians who do not participate in Medicaid and who practice in towns with relatively insufficient number of physicians providing primary care to children under 21 under Medicaid.

GOAL: To develop, implement and evaluate a PGH recruitment program for Segment C physicians.

NUMBER	WORKSTEP DESCRIPTION	ORGANIZATION RESPONSIBLE FOR COMPLETION
*C.1.	Identify Segment C physicians. To do so, CHF analyzed PGH physician participation and client eligibility data. Using these data, and estimates of physician caseload available to Medicaid recipients, CHF estimated that there are two regions of the state with a relatively insufficient number of primary care physicians currently serving Medicaid recipients. These regions are Springfield and Lawrence. (June 1981)	CHF
*C.2.	Convene two (2) focus groups of eight (8) to fifteen (15) Segment C physicians. One group covered in Springfield, one in Lawrence. To convene focus groups CHF contacted the director of the Massachusetts Academy of Pediatrics chapter and solicited names of contact people in these two communities. CHF then contacted the physicians recommended by the chairman and asked them to help arrange meetings with Segment C physicians. Focus groups were convened on November 10-11, 1981. (November 1981)	CHF
*C.3.	Develop a written survey questionnaire based of an analysis of focus panel results. The purpose of the survey is to gather quantitative information to confirm or modify qualitative information received from the focus panel. (December 1981)	CHF
*C.4.	Arrange with the Massachusetts Chapter of the American Academy of Pediatrics to distribute questionnaire to all academy members. (February 1982)	CHF/PGH
*C.5.	Distribute questionnaire. (February-March 1982)	PGH/AAP
C.6.	Analyze results and identify new physicians to be recruited and learn of programs strengths and weaknesses as perceived by the various physicians who responded.	PGH
C.7.	Develop new market sub-segments based on the physician practice data and responses to the questionnaire.	PGH

PGH MARKETING PROGRAM
WORKSTEPS

SEGMENT D: Community Health Centers

Goal: To develop, implement and evaluate a PGH recruitment program for Community Health Centers (CHC).

NUMBER	WORKSTEP DESCRIPTION	ORGANIZATION RESPONSIBLE FOR COMPLETION
*D.1	Conduct an assessment of current CHC participation in PGH. The assessment included personal contact with administrator of each CHC to determine (a) whether or not the CHC was intending to participate in PGH and (b) what problems the CHC's see in participating in the program. As a result of the assessment, three (3) groups of CHC's were identified: Group I: Intend to participate Group II: Intend not to participate Group III: Intend not to participate for a variety of programmatic reasons not related to computerized billing. (October 1981)	PGH/CHF
D.2.	Conduct marketing programs for each group. The emphasis will be on product redesign to accomodate to CHC's needs for automated reporting and billing parameters.	PGH
D.3.	Identify issues pertinent to computerized billing and develop action plan to involve CHC's with computerized billing in PGH.	PGH
D.4.1.	Convene meeting of Group III centers to discuss issues pertinent to non-participation.	PGH
D.4.2	Analyze results of the meeting and discuss with state PGH staff.	PGH
D.4.3.	Develop a recruitment/retention program for Group III centers.	PGH

PHYSICIAN RECRUITMENT:

A

MARKETING APPROACH

A. WHAT IS MARKETING?

Marketing is the task of finding and securing consumers for a firm's output. Through marketing a firm develops an understanding of consumers' needs. This understanding enables the firm to offer services or products consistent with these needs. In contrast to private firms, public agencies and social service organizations market a "program" rather than a "product." However, the principles of marketing are no less applicable: public agencies, like private firms, must find, secure and retain consumers. Within the context of physician recruitment, the physician is the consumer to whom PGH is trying to market a product, the PGH program.

To be successful, a marketing program must also include the elements of sound planning. The program must define, accomplish and evaluate objectives rather than simply prescribe an advertising or sales campaign. The CHF approach incorporates a planning component.

B. A MARKETING APPROACH

In the past, most state PGH programs, Massachusetts included, have approached physicians as an homogeneous mass. For example, when states have program information to disseminate, they send a single message to everyone. Usually states send a letter to physicians, or arrange a meeting or series of meetings with a single agenda. This approach does not recognize the characteristics which may distinguish one group of physicians from another. There are many possible groupings, such as geographic location, current Medicaid participation status, type of practice, specialty, and academic affiliation.

A sound marketing approach will first identify the various groupings, or market segments which are relevant to the objectives to be achieved.

Secondly, since there are only limited resources available to convince physicians to participate, states must concentrate these resources to maximize the desired effect--physician participation. Marketing experts advise us that the most efficient approach utilizes diffusion theory. Diffusion theory suggests that some segments, and some members of each segment, will be quicker to adopt innovation and change than others.

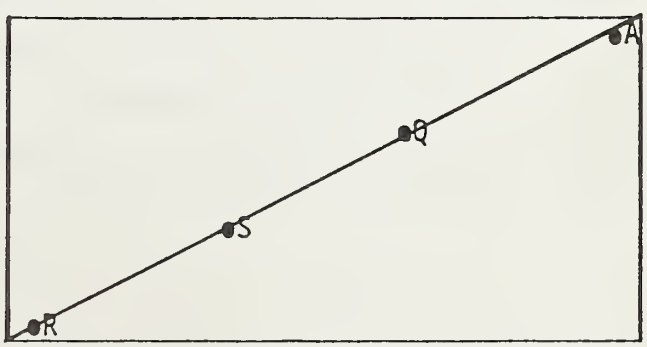
State EPSDT programs can use their marketing resources most efficiently by first targeting the easiest to change. By focussing on a single market segment, or sub-segment, states can concentrate their resources efficiently and effectively and demonstrate successes in a shorter period of time and at less cost than by communicating to all segments at once. The first successes initiate the diffusion process. Building on successes is a basic tenet of marketing and is especially relevant to state programs with limited resources at their disposal for marketing EPSDT.

Third, once target segments are identified, the next objective is to convince members of the segments to purchase PGH. There are four (4) stages to the purchasing process. These stages are:

- Awareness
- Qualification
- Selection, and
- Retention.

The chart below depicts the relative amount of personal versus non-personal contact associated with stages of the process.

- Awareness
- Qualification
- Selection
- Retention



100% Non-Personal

100% Personal

As the chart shows, each stage of AQSR requires somewhat different techniques.

Awareness can be accomplished by non-personal techniques. Letters, invitations, display advertising, posters and public service announcements are all effective tools for creating awareness of a product.

Qualification requires more specialized information for the individuals who comprise the market to determine if they qualify, i.e., if the product is "for them."

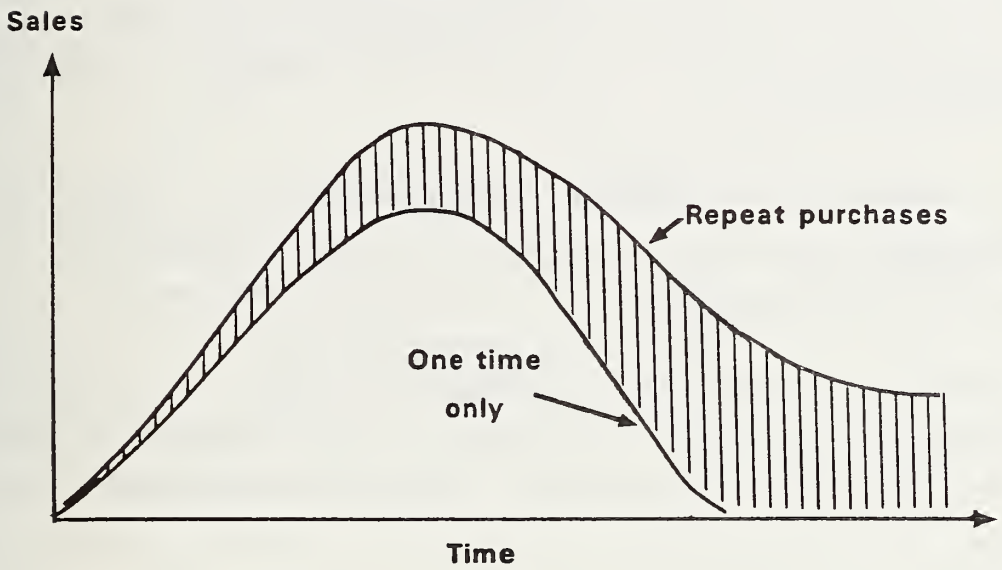
Selection requires the individuals to make a decision to "select," or purchase the product. This requires personalized information, often in the form of a personal selling campaign.

Retention, is crucial to a marketing approach, but often overlooked by government agencies. Retention activities are the most cost effective because they have the greatest marginal value. It is generally much less difficult and expensive to keep physicians interested than it is to convince them to participate in the first place. Since each physician already participating has had a unique experience with the program, a personal approach is necessary. Nevertheless, there are some non-personal activities which can be undertaken for this component as well. A newsletter or periodic report on program accomplishments are two examples of non-personal techniques appropriate for the retention stage. (See Diagram 1)

Supervisors can also use the AQSR approach to help determine assignments for their marketing personnel. For example, calling or visiting a participating physician to inquire about problems and say a few words of encouragement and appreciation is a considerably different task than trying to sell the program to a non-participating physician. The latter task will require more concentrated selling skills, more facts, training and technical competence.

Diagram 1

VALUE OF RETENTION PROGRAM



The marketing approach must also consider the product itself. (See Diagram 2.) The product, in this case PGH, must be tailored to meet clients' (physicians') needs.

There is more than one level of produce which must be considered. PGH encompasses many ideas, images and feelings.

At the most basic or "core" level PGH is the completion of the billing form in exchange for which the state pays $26.50. At the "formal" product level PGH represents the outreach, referral and case management systems which distinguish PGH from Medicaid.

Finally, the "augumented" PGH programs include the emphasis on preventive health care and the intention for the state to actively offer services designed to keep children healthy.

Using the approach discussed above, this Manual outlines a six-part Marketing Plan. CHF hopes that PGH staff will use the Plan as a cornerstone of their provider recruitment and retention efforts. The elements of the Plan are as follows:

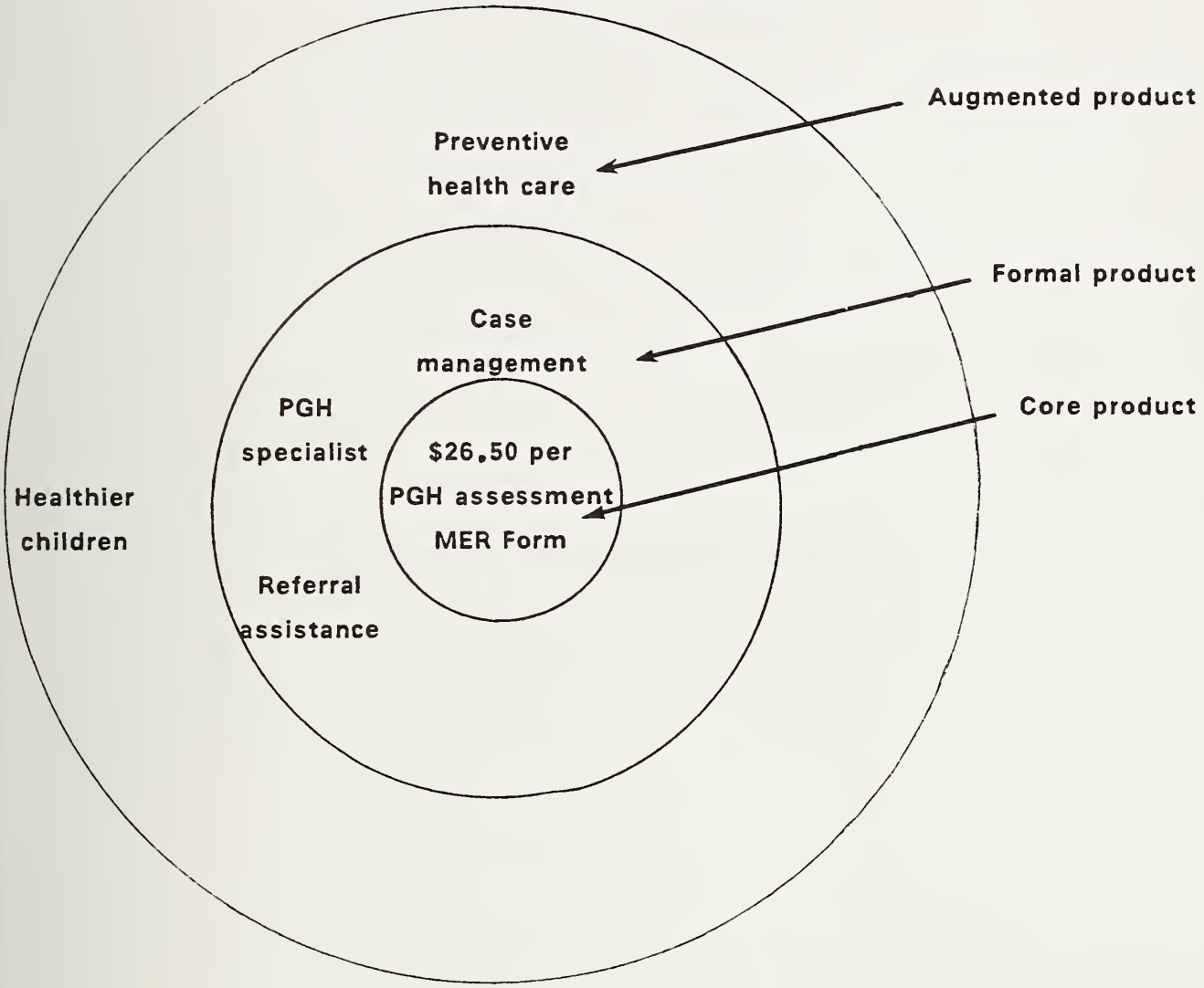
A. Market Identification
B. Market Segments
C. Targeting Market Segments
D. Marketing Program for Each Targeted Segment

The appendices to this Manual include samples of questionnaires, training exercises and journal articles, which will be useful in implementing each element of the Marketing Plan.

The worksteps from the CHF Provider Recruitment Methodology are included as Appendix 12 as an example of a marketing plan for four market segments.

Diagram 2

THREE LEVELS OF PRODUCT



SECTION III. THE PGH MARKETING PLAN

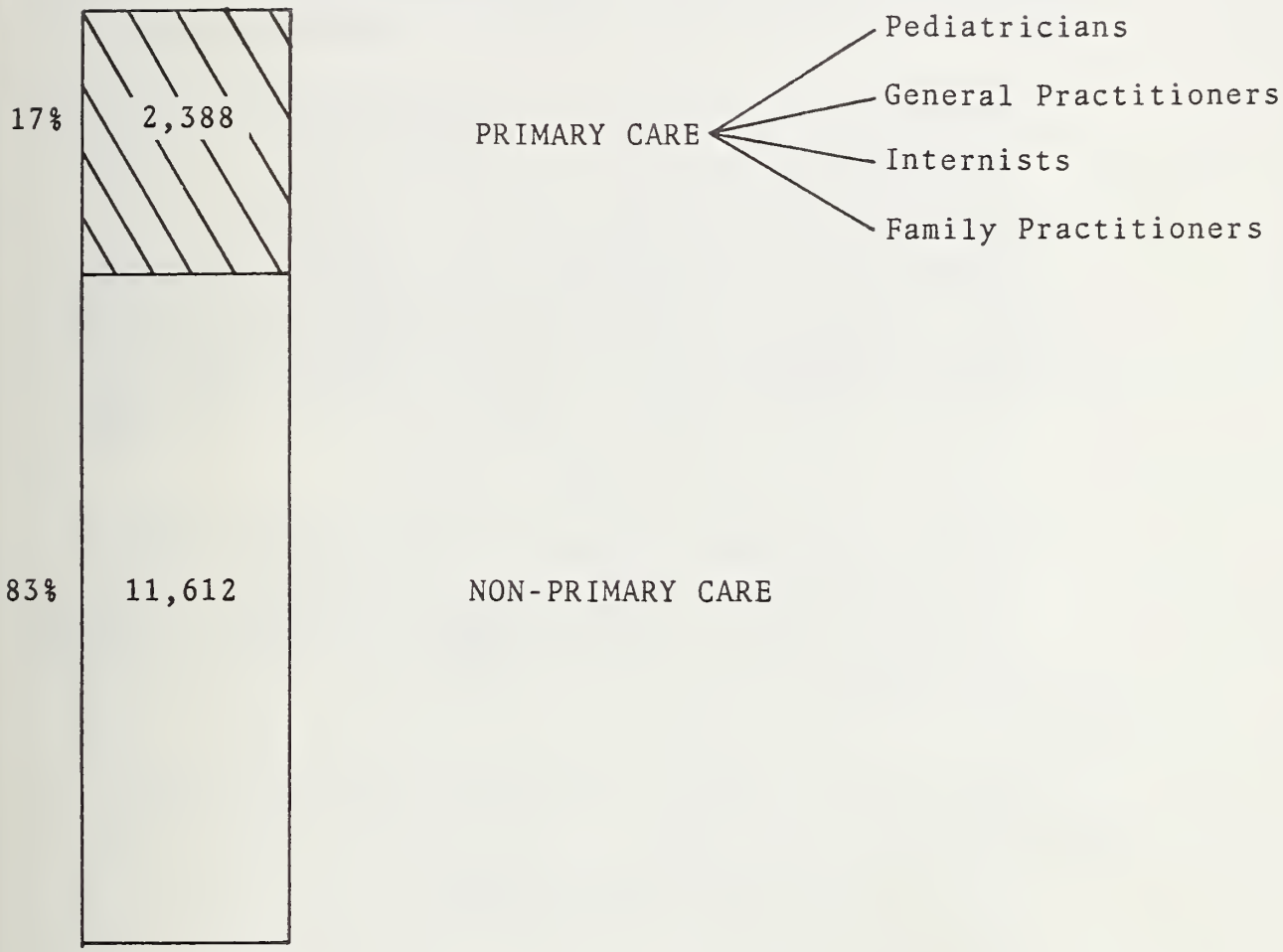
A. Market Identification

The first objective of the Marketing Plan is to identify the potential pool of providers who can deliver PGH services. This group is the "market." Since PGH services are basically secondary prevention services, the market is primarily composed of physicians who provide primary care. These physicians include pediatricians, internists, family practitioners, and obstetrician-gynecologists. As Diagram 3 shows, there are 2,388 primary care physicians in Massachusetts. This total represents about seventeen percent (17%) of all the physicians in the state.

It is unlikely that the definition of the market (primary care physicians) will change in the near future. In some states, physician mid-level health practitioners (nurse practitioners and physician's assistants) are permitted to practice independently. However, mid-levels in Massachusetts are not currently permitted to provide primary care services independent of a physician's direct supervision.

DIAGRAM 3

14,000 PHYSICIANS IN MASSACHUSETTS



B. Market Segments

Identification of market segments is an essential part of the Marketing Plan. Because there are too many physicians located in diverse geographic areas, practicing in different practice settings and serving different population groups, it is unlikely that a single marketing program would succeed in changing the behavior of all such groups. CHF recommends three (3) techniques PGH staff should use to identify physician market segments.

1. The Review of the Literature on Physician Participation in EPSDT/Medicaid (Appendix 1) identifies a number of different ways of defining the market segments. The market can be segmented by practice location (city, region); practice type (solo, group, pre-paid health plan, community health center); practice specialty (general pracice, pediatrics, internal medicine, OB/GYN); patient income (low, middle, high); and current or prior participation in Medicaid.

   The Review of the Literature is current as of July, 1981. PGH staff should periodically update the Review, to keep themselves appraised of recent research in provider recruitment and marketing.

   PGH staff should find the following journals to be useful resources in this effort:

   - American Journal of Public Health
   - Group Practice
   - Harvard Business Review
   - HCFA Forum
   - Health Care Financing Review
   - Health Care Management Review
   - Health Services Research
   - Hospitals
   - Journal of Ambulatory Care Management
   - Journal of Human Resources

- Journal of Marketing
- Journal of Marketing Research
- Journal of Medical Management
- MGMA Journal
- Medical Care
- Medical Care Review
- Medical Economics
- Milbank Memorial Fund Quarterly
- Modern Healthcare
- Pediatrics
- Public Health Reports

2. A Needs Assessment of the PGH program (Appendix 2) was conducted by CHF staff. The Needs Assessment helped CHF identify prior participation in PGH (through a Provider Contract) and practice type (Community Health Centers, all other physicians) as relevant segments.

   CHF recommends that PGH use the Needs Assessment as a guide for annual evaluations of the Project Good Health program. The Needs Assessment covers eight (8) major areas of program operations, including Program Management, Provider Resources, Identification and Notification of Eligibles, Outreach, Screening, Diagnosis and Treatment and Case Management. Based on the results of the Needs Assessment, PGH staff can identify areas of program operation which need enhancement. The findings will assist provider recruitment efforts, by identifying weaknesses in the PGH product which may be contributing to provider dissatisfaction.

3. Lastly, an Analysis of Physician Participation Data (Appendix 3) identified certain physician specialities (general, family practice, pediatrics) as a relevant market segment. The Data Analysis also identified practice location as a relatively unimportant variable, since physician participation in PGH and Medicaid were uniformly low throughout the state.

Based on the results of these three efforts, CHF recommends that Project Good Health develop marketing programs for the following specific segments.

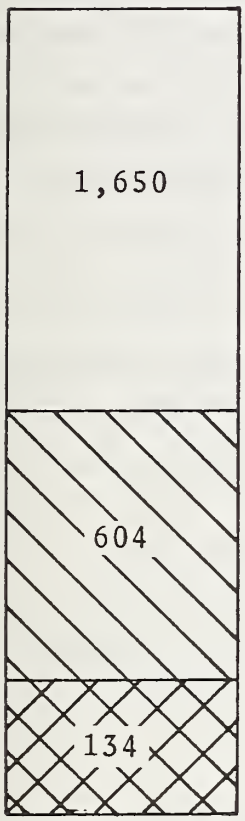
Segment A. Physicians participating in Project Good Health. This market segment can be classified for Retention according to the AQSR paradigm. There were 191 physicians participating in Project Good Health as of November 30, 1981. (Diagram 4)

Segment B. Primary Care - Physicians currently participating in the Massachusetts Medicaid program, but not in PGH. There are 527 physicians in this category. (Diagram 4) This market segment is classified for Qualification and Selection, according to the AQSR paradigm.

Segment C. Primary Care Physicians who do not participate in Medicaid or PGH currently and who practice in regions/towns with an insufficient number of physicians who provide primary care under Medicaid. In analyzing the Massachusetts physician data, CHF estimates that there are a sufficient number of physicians who currently participate in Medicaid to serve the Medicaid eligible population under 21 years of age in all regions of the state. Because of the paucity of data concerning interregional migration of clients to physicians' offices, CHF cannot be town-specific in its targeting. Currently, the Springfield and Lawrence regions have relatively low number of primary care physicians already participating in Medicaid. Because of this these two regions should be targeted for the recruitment of physicians who are not participating in Medicaid. PGH staff should revise the Data Analysis annually to assess whether or not these regions are still relevant market segments. This segment will require Awareness as well as Qualification and Selection programs.

DIAGRAM 4

2,388 PRIMARY CARE PHYSICIANS



69% NON-MEDICAID

25% MEDICAID-NON PGH
(Serving children)

6% PGH AND MEDICAID

Segment D. Community Health Centers. Massachusetts has the most extensive community health center network in the country. Most of the health centers serve predominantly low-income and Medicaid-eligible families. The centers are established to provide quality, comprehensive health services to low income people in need of government support. All these health centers already provide Medicaid services and many have been providing Project Good Health or its equivalent to the Medicaid eligible population under 21. Community health centers are an ideal resource for Project Good Health. Recognizing their potential to serve PGH eligibles, the state adopted changes in Project Good Health which were designed, in part, to provide incentives for Community Health Centers to provide Project Good Health services. Community Health Centers now receive a financial incentive of $5.50 more than the current Medicaid reimbursement rate if they participate in Project Good Health.

C. Targeting Market Segments

Marketing principles can be used to achieve the most efficient use of the state's resources. This objective can be achieved by targeting specific segments. Specific approaches to recruitment will be developed for each of the target segments. Targets are selected based on the likelihood of the success (successful recruitment to PGH) and the impact successful recruitment would have on the overall goal of recruiting sufficient number of providers. While certain segments may meet some criteria and not others, the targets should be selected so that together they provide the best chances of success and most efficient use of the state's limited resources.

Segment C physicians in non-underserved areas should not be targeted initially for recruitment since these physicians are (1) the least needed by the program and (2) the most difficult to recruit.

CHF recommends that PGH should revise it's targeting plans semi-annually. Each year, PGH should assess (1) the availability of its provider marketing resources and (2) the segments most in need of recruitment and retention. Accordingly, a new targeting plan can be developed.

Based on its experience in developing this plan, CHF believes that:

- Retention (Segment A, part of Segment D) should be a key component of each year's target plan. It is much easier to retain physicians and centers than to recruit them in the first place.
- Non-participating centers in Segment D should be recruited heavily in the next year, since their interest in Medicaid and potential impact on penetration rates are great.
- Segment B physicians should be recruited heavily in the next two-three years, until penetration and retention rates have improved markedly.

D. PGH Marketing Programs

This section outlines marketing programs for the four (4) market segments. Appendix 5 includes marketing tools (questionnaires, training exercises and promotional materials) which PGH staff can use to implement these programs.

1. A Retention Program for PGH Physicians (Segment A), is crucial to a marketing plan, but often overlooked. Retention activities are the most cost effective because they have the highest marginal value. It is generally much less difficult and expensive to keep physicians interested than it is to convince them to participate in the first place.

   The PGH Retention Program will follow the Field Staff Central Office Recruitment/Retention Flow Chart, Diagram 5. PGH field staff (specialists, technicians, and supervisors) will have primary responsibility for the Retention Program. As outlined in Diagram 6, field staff will have four (4) major duties in the Retention effort. On a regular basis, field staff will receive data on physicians participating in PGH. These data will be used to plan the retention programs. Based on the data, field staff will arrange a call schedule* for each physician. Using a Program Checklist*, field staff will conduct a telephone or personal interview with each physician.

   Staff should also know how to handle complaints which physicians raise during the interview*. Subsequent to the interview, staff will complete and submit to Central Office a Retention Visit Report*. The Report will outline physician's complaints about PGH, and recommend actions which Central Office and field staff can take to resolve these complaints.

   Field staff may also want to distribute a mail questionnaire* to PGH physicians. The questionnaire could be used as a supplement or complement to telephone and personal interviews.

*Samples of these items are included in Appendix 5, Provider Retention/Recruitment Training Program.

Diagram 5

PGH FIELD STAFF/CENTRAL OFFICE RECRUITMENT/RETENTION FLOW CHART

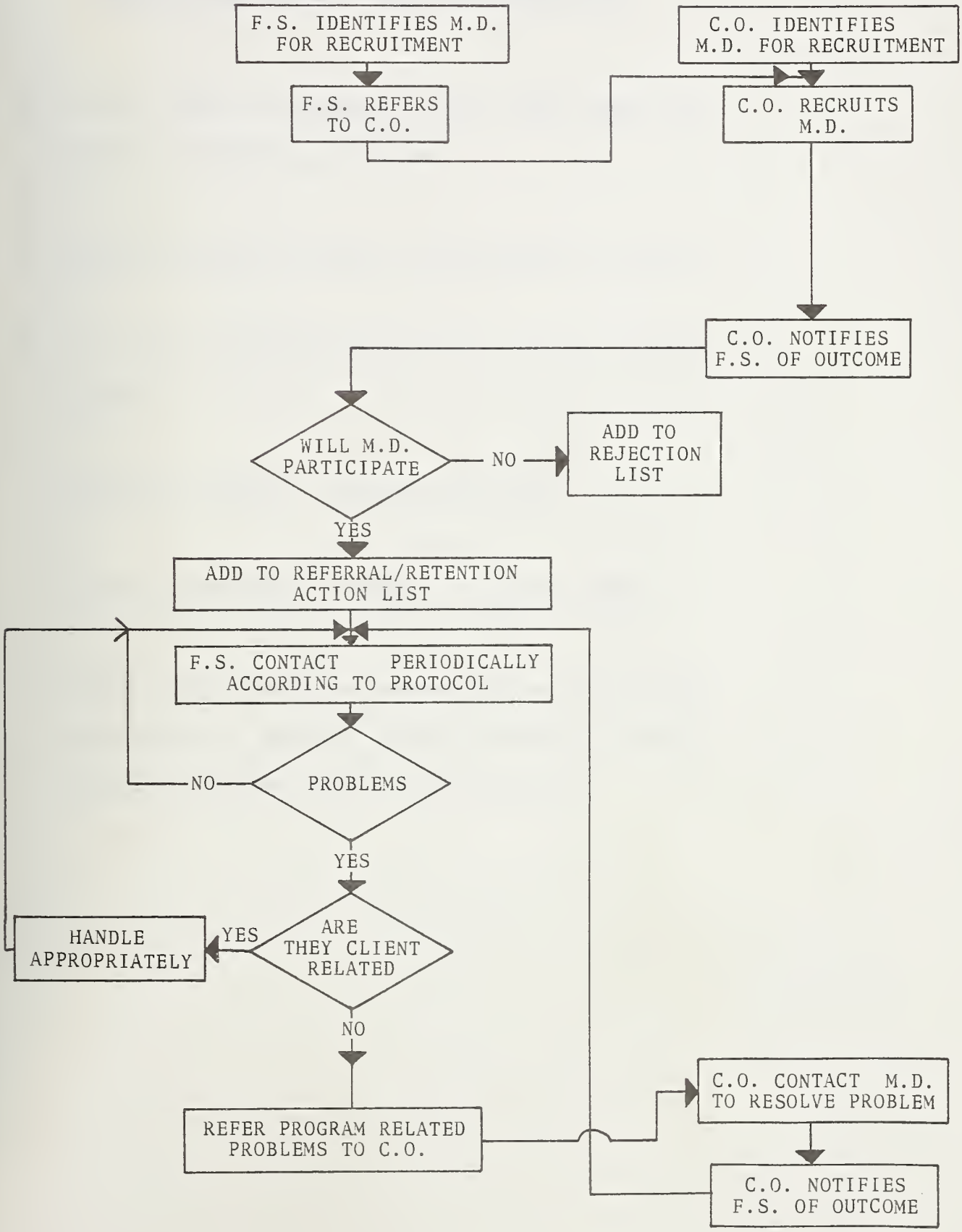


DIAGRAM 6

ROLE OF THE PGH SPECIALIST

1. Friend, ally of physicians (you need them to deliver services to children)

2. Identify new providers in community to recruit

3. Contact each periodically to learn of and satisfy needs

   - Client related -- handle yourself

   - Administrative -- refer to central office

4. Make sure physician is aware of your role in Case Management System (and how the properly completed MER makes it all possible)

Periodically, PGH staff should also reevaluate their retention activities.

Staff can also use non-personal techniques to enhance physician retention. As an example, PGH can secure free or discounted passes from local institutions such as the Boston Children's Museum. Passes can then be distributed to PGH physicians as "thank you's" for participation in PGH. The complete Training Program Manual, which CHF used to train PGH field staff on the PGH Retention Program is Appendix 5.

2. A Recruitment Program for non-PGH, Medicaid Physicians (Segment B) Recruitment of physicians billing Medicaid for well-child examinations (instead of PGH) is essential for PGH success. The most effective method of recruitment for these physicians is a personal selling campaign. A personal selling campaign has been conducted by PGH Central Office staff to recruit the top 100 Medicaid-billing physicians in areas most in need of Medicaid physician services. A method for evaluating this and other recruitment campaigns is Appendix 6. PGH staff could also use a mail questionnaire as an evaluation tool. This is included as Attachment 2 to Appendix 6.

   In recruiting Medicaid physicians for PGH staff should be prepared to respond to several common questions about PGH*. Staff should be prepared to explain to physicians the major differences between the 'old' and the 'new' PGH program*. In telephoning a physician, to arrange an appointment, staff should attempt to follow the initial contact protocol* CHF developed.

*Samples of these items are found in Appendix 7. These are excepts from the Resource Guide CHF prepared for the training program CHF conducted on May 27, 28, 1981.

3. Recruitment Program for Non-Medicaid Physicians (Segment C)
Non-Medicaid physicians will be the hardest to recruit for PGH. These doctors have already decided for any number of reasons not to either serve welfare patients or bill Medicaid programs for their services. For this reason, PGH should initially devote the least amount of resources to recruit these physicians. Recruitment techniques should be similar to those outlined in #2 (personal selling, invitation and response card).

PGH can use non-personal techniques to increase awareness including the printed invitation and response card, which CHF has prepared for the PGH program (Appendix 8). Higher awareness will make any later personal selling efforts more efficient.

Another technique which PGH staff can use to collect research data on the needs and interests of physician's is the focus group. The focus group is a qualitative research technique developed for use in consumer research. It's use in assessing physician interest in PGH has been demonstrated this past year (Appendix 9). Staff who have received training in conducting focus groups may want to apply this technique in future physician marketing either of Medicaid or non-Medicaid physicians. A sample Interview Guide, which CHF used in conducting focus groups is Appendix 10.

The complete Training Program on Marketing Approach to Provider Recruitment which CHF used to train PGH Central Office staff in the PGH Recruitment Program is Appendix 11.

4. Community Health Center (Segment D)

Because of their large volume of patients and other unique characteristics, CHC's have different administrative policies, procedures and systems than most other providers. They therefore should be considered a separate segment. Since there are considerable geographic, size and patient characteristic differences among CHC's, PGH should divide them into smaller groups as part of a marketing plan.

The largest CHC's offering services to PGH eligibles should be approached individually by PGH central office staff. Their participation is essential for PGH success. Many have automated billing and management information systems. These will find it difficult to complete hard copy reporting and filing forms.

Recognizing CHC's potential to serve PGH eligibles, the state changed Project Good Health to motivate community health centers to participate. Community Health Centers now receive a financial incentive ($5.50 more than the current Medicaid reimbursement rate), to participate in Project Good Health. Although there is considerable interest and willingness to provide Project Good Health services, the $5.50 premium is insufficient motivation for most.

PGH and Medicaid will have to work with these health centers to develop compatible automated billing and reporting mechanisms to accommodate their needs. The problem PGH encountered with CHC's was indeed, administrative. PGH and certain CHC's continue to negotiate the arrangements to submit billing and reporting tapes acceptable to Medicaid and PGH.

APPENDIX A

NEEDS ASSESSMENT QUESTIONNAIRE
PROJECT GOOD HEALTH

I. PROGRAM MANAGEMENT

A. Organization

1. List the names and titles of individuals in the major categories of the Project Good Health (PGH) organizational chart. Include telephone numbers for each person. What are the job reponsibilities of these top positions?

2. What are the PGH positions at the state level?

3. How is PGH administered on the regional/local level?

   a. What are the PGH staff positions?

   b. What is the involvement of local health and welfare agencies?

B. Communication

1. How is basic PGH program information disseminated to:

   a. PGH personnel?

   b. Relevant health and welfare agencies?

   c. Regional and local levels?

C. Goals and Objectives

1. Have goals and objectives been formulated for the PGH program? What are they?

2. What is the time table for implementing goals and objectives?

3. How often are goals and objectives reviewed?

4. Who participates in reviewing goals and objectives?

D. Policy and Planning

1. Who has the primary responsibility for policy? Where is this person in the organizational chart?

2. Who has input into policy?

   a. What opportunities are there for community input?

   b. For provider input?

3. Are there PGH advisory or policy groups?

   a. If yes, do they contribute to policy making or do they serve in an advisory capacity only?

   b. Who are the members?

   c. How often do they meet?

4. How are policies reviewed?

   a. By whom?

   b. How often?

E. Monitoring

1. How does the state monitor the local delivery of PGH services?

2. Who is responsible for monitoring? (State field staff?)

F. Evaluation

1. Has the state evaluated the PGH program? If so, how and by what criteria?

2. What management needs or deficiencies of the program have been identified by the state?

II. PROVIDER RESOURCES

A. What is the process and who is responsible for identifying provider resources at the state and the county levels in the following program aspects?

   1. Providers for screening?

   2. Providers for diagnosis and treatment?

   3. Transportation?

   4. Dental providers?

   5. Other referral resources, e.g., developmental, vision or hearing?

B. Are there directories listing these resources at the local level?

C. Are there deficiencies in available resources for PGH?

   1. In the areas of:

      a. PGH dedicated staff (numbers and skills)?

      b. Providers (for screening, diagnosis and treatment)?

      c. Available funding (administration, travel, marketing, outreach)?

   2. Have steps been taken to meet identified resource needs?

   3. What plans exist to correct these deficiencies?

D. What are the formal policy positions and actions concerning PGH taken by professional associations?

   1. At the state level?

   2. At the lower level?

E. What informal relationships exist with professional societies?

F. What is the reimbursement rate to providers for PGH services?

1. Complete screening?

2. Partial screening?

3. Transportation?

G. What material (forms, brochures, manuals, etc.) are distributed to providers?

(PURPOSE OF QUESTIONS: To explore the experience and perceptions of providers, participating and non-participating, relating to the Medicaid program in general and EPSDT in particular. These questions can also be used to interview representatives of professional organizations.)

1. How would you characterize the level of your participation in the Mediciad program? (or of the members of your professional organization). Define what you mean by "minimal", "significant" etc. in terms of percentage of patients, or percentage of patient billings.

2. Do you provide EPSDT?

3. Do you accept all Medicaid patients who request services? Or do you limit the size of your Medicaid caseload? Why? How?

4. Do you alter the pattern or place for treatment of Medicaid patients? i.e. certain days or time for Medicaid patients? If so, why?

5. Why do you limit your participation in Medicaid/or choose not to participate in Medicaid? How would you prioritize your reasons? Break reasons down into those that are program-specific and client-specific.

- Inadequate reimbursement or fees
- Administrative complexity
- Delays or inordinate justifications involved in obtaining reimbursement
- Loss of professional autonomy
- Fear of Federal controls
- Changing or indeterminate client ineligibility
- Attitude toward Medicaid clients

6. How would you characterize the level of Medicaid reimbursement for your state compared with your usual and customary fee? Are there variations in level of reimbursement across provider groups? Does this affect your desire to participate?

7. Are there any problems unique to the EPSDT program that affect your willingness to participate?

8. How did you arrive at your decision to provide/not to provide EPSDT services? Through what channels were you informed about the program?

9. How do you find out about new developments/changes in the Medicaid program? The EPSDT program? Are you kept adequately informed of new developments that have an impact on your practice?

10. What is the nature of your relationships with state agencies or fiscal agents?

11. Have there been any recent legal battles or controversies between provider associations and state Medicaid agencies that have affected your willingness to participate or the level of your participation in Medicaid/EPSDT?

12. What positions have your professional organizations taken on these issues? How influential are they in shaping your attitude toward Medicaid/EPSDT? Do they encourage/discourage participation? Do they play an active role in disseminating information?

13. How would you characterize your relationship with the Federal government? (Degree of trust and mutual respect, quality of communication, extent of cooperation, impact of fraud and abuse initiatives).

14. Does the prospect of a "Medicaid cap" affect your attitude toward/willingness to participate in the program?

15. What policy or administartive changes in the program do physicians recommend as incentives to greater participation?

16. Is there any apparent correlation between the extent of physician participation and state Medicaid policy? (Reimbursement levels, or methods, coverage levels or limitations, forms or billing procedures).

17. What are your impressions about Large Medicaid Practices? (i.e. over 30-40% Medicaid patients?)

- Type of provider likely to go into this sort of practice
- Possible motives/incentives
- Quality of care provided
- Reputation among peers

18. How might you characterize a typical EPSDT provider? What type of doctors would be most likely/least likely to provide EPSDT services?

III. IDENTIFICATION OF ELIGIBLES

A. Who are the eligibles?

1. What are the criteria for PGH eligibility (i.e., AFDC, SSI, medically needy, etc.)?

2. How many are eligible for PGH? How has this number changed over the past three years?

3. Is there a predominance of eligibles in particular regions/towns?

4. What is the number of eligibles screened?

   a. Per quarter?

   b. What percent of the total number of eligibles are current according to the rescreening schedule?

B. Identification Procedures

1. How does the state identify eligibles?

2. How is the fiscal intermediary informed?

3. How does the provider identify eligibles?

4. What is the procedure for adding a client's name to the list of eligibles?

5. How long does it take before a claim can be processed on the client's behalf after eligibility determination?

C. Eligibility Time Period

1. What is the eligibility turnover rate? (What is the average length of time families are on the Medicaid rolls?)

2. Is the turnover rate a problem?

3. If a person becomes ineligible during the course of treatment, is treatment continued?

IV. NOTIFICATION OF ELIGIBLES (REQUIRED INFORMING)

A. How are eligibles notified?

   1. When?

   2. How often?

   3. By whom?

   4. What information is included?

B. What methods are used to notify the blind, illiterate or non-English speaking?

C. What outreach efforts are used to contact parents who initially refuse participation in the program?

D. What efforts are made to verify that clients are receiving some other type of care and the nature of that care?

E. Are clients' requests for screening or supported services documented?

F. Who provides the assistance?

V. OUTREACH

A. Responsibility for Outreach

1. What is covered under "outreach"?

2. What agencies are responsible for outreach?

3. Are there outreach contracts with community organizations?

4. Who does outreach? (Social workers? Nurses? Paraprofessionals?)

   a. Do these individuals have other responsibilities?

   b. How much time is devoted to outreach?

5. Is there client participation in setting outreach policy?

B. Outreach Targets

1. How is the outreach target population defined?

2. Are there target population priorities (e.g., geographic accessibility, newly eligible, missed appointments, specific age groups)?

C. Outreach Procedures

1. What is the nature of the initial contract?

2. What material is left with the client?

3. What is the nature of subsequent contracts?

D. Training

1. Are there state and/or local training programs for PGH outreach workers?

   a. What training is provided?

   b. How often?

   c. Are outside agencies or community organizations involved in training?

E. Support Services

1. How are arrangments made for transportation?

2. How are arrangements made for day care?

3. How are arrangements made for other support services?

VI. SCREENING

A. Resources

1. What types of providers are recognized as screening agents?

   a. Public
   b. Private
   c. Schools
   d. Community health centers
   e. Other

2. If any types are not recognized, what is the basis for this?

3. What percentage of all services is each sector providing?

4. Are there adequate screening resources? Are they appropriately distributed?

5. How are private providers recruited?

6. How are providers monitored?

7. Is there a training program for screening providers?

8. Are nurse practitioners and physicians' assistants recognized as screening providers?

9. Are there screening contracts with providers, e.g., HMO's, Head Start, neighborhood health centers, Title V programs, private physicians, schools?

B. Services

1. What is the screening package?

2. Is there a separate screening invoice form?

3. How are lab tests billed?

4. What is the policy for claims payment when the screening form is incomplete?

5. Are provider claims for well-child care honored if they are billed on regular Medicaid forms?

6. Are these children counted as PGH recipients?

7. If yes, how does the state assure that the full complement of PGH services is provided?

8. How does the state encourage the use of the PGH screening form?

C. Communication

1. Are the results of screening reported to the parent? Are they interpreted?

2. Do parents receive a copy of the screening form or some other record of screening? Is it interpreted for them?

3. Can other institutions (schools and day care centers) as well as referral providers receive adequate and appropriate information about screening results?

4. Is the screening package and schedule routinely reviewed?

D. Claim Forms

1. What percentage of screening invoices are rejected?

2. For what reasons?

   a. incomplete
   b. ineligibility
   c. utilization review
   d. other

VII. DIAGNOSIS AND TREATMENT

A. Referral Process

1. What information is forwarded from the screening to the diagnosis and treatment providers?

   a. Who is responsible for forwarding?

   b. What forms are used?

   c. How is this information transmitted?

2. How are the results of diagnosis and treatment transmitted from the referral provider back to:

   a. The screening provider?

   b. The child's health record?

   c. The case manager?

3. What forms are used by the referral provider?

4. What is the average lag time between a positive screen and a provider visit?

5. What is the referral procedure for clients who need a physician specialist?

B. Dental Services

1. What is the procedure for referrals to a dentist?

2. Are all children age 3 and over referred to a dentist?

C. Support Services

1. Are transportation and other support services available for diagnosis and treatment services?

2. How are they arranged?

D. Billing Forms

1. How are PGH related diagnosis and treatment services invoiced?

2. What forms and codes (PGH) are used?

3. Are all PGH related services identified?

VIII. CASE MANAGEMENT

A. Flow Charts

1. Draw a patient flow diagram from the point of eligibility to completion of treatment.

2. Note any areas where the system "breaks down" or does not have the capability to handle a likely occurrence.

B. Organization

1. Who is responsible for case management?

2. What percent of time is devoted to case management as compared to other functions?

3. How does the state monitor case management?

C. Procedures

1. Are there written procedures for case management?

2. What kind of training do the case managers receive:

   a. Initially?
   b. On-going?

3. Are priorities established for certain types of cases?

4. What follow-up is there for children with chronic problems?

5. Describe the system, manual or automated, which accounts for the performance and documentation of each of the following steps in the PGH process.

   a. Initial notification
   b. Periodic notification
   c. Arrangement of services requested
   d. Client reminders
   e. Missed appointments
   f. Results of screening
   g. Referral for abnormal conditions

D. Broken Appointments

1. What is the percentage of broken appointments?

2. Does the state receive provider complaints about missed appointments?

How are they handled?

APPENDIX B

PROJECT GOOD HEALTH

PROVIDER RETENTION/RECRUITMENT
TRAINING PROGRAM
SUPERVISORS, SPECIALISTS, TECHNICIANS

Community Health Foundation

Management Analysis Center, Inc.

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SECTION

Active Listening Skills

PGH Self-Assessment

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- Approach and Concepts
- Components
- Roles

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How to Respond to Provider Problems
- Retention Visit Report
- Retention Visit Checklist
- Complaints

Role Play: Provider Visits

Effective Communication Processes

Evaluation Forms

PROJECT GOOD HEALTH
PROVIDER RETENTION/RECRUITMENT
TRAINING SEMINAR
February 16-17, 1982

AGENDA

Time		
9:30-9:45	Sharing of Objectives & Agenda Experiential Approach	Project Good Health Staff/ Community Health Foundation Staff
9:45-10:15	Warm-Up Activity Active Listening	Sheila O'Shea-Bolton
10:15-10:45	Project Good Health Self-Assessment Discussion	Joseph Liberatore
10:45-11:00	BREAK	
11:00-12:00	PGH Provider Retention/Recruitment Program -Approach & Concepts -Components -Roles	PGH Staff/CHF Staff
12:00-12:30	Small Group Task List Benefits of PGH Provider Recruitment/Retention Approach -Discussion	Sheila O'Shea-Bolton
12:30-1:30	LUNCH	

1:30-1:50	Small Group Activity Problem Situation 1. Whom Do I Contact? 2. When Should I Do It? 3. How Do I Contact Them?	Joseph Liberatore
1:50-2:10	Group Reports and Discussion	
2:10-2:30	How to Respond to Provider Problems -Problem Identification -Client Centered/Non-Client Centered Problems -Retention Visit Report Form	Michael Gelder
2:30-3:45	Role Play Provider Visits Case Situation A BREAK Case Situation B Group Discussion	CHF Staff
3:45-4:15	Effective Communication Processes Related to PGH Provider Retention	Sheila O'Shea-Bolton
4:15-4:30	Summary and Evaluation	Sheila O'Shea-Bolton

February 16, 1982 Meeting

Howard Johnson's Motor Lodge
800 South Bridge Street
Worcester, MA 01610

February 17, 1982 Meeting

Holiday Inn
339 Grove
Newton, MA 02162

ACTIVE LISTENING SKILLS

There are two communication skills which can be used to ensure that the receiver has understood the ideas, information, suggestions and feelings of another person sending messages:

Skill: Paraphrasing - stating in your own words what the other's remarks mean to you.

- checking with the other person to be sure you understand her/his remark, message or suggestion as she/he intended it.

Example: "Your major point is _____."

Example: "The problem as you see it is _____."

Example: "Is this statement an accurate understanding of your points? _____."

Skill: Perception Checking - Purpose is to understand the feelings of another person.

Perception Check - describe what you perceive to be the other person's inner state in order to check whether you understand what she/he feels.

Example: "I get the impression you are angry with me? Are you?"

It does not convey approval or disapproval of the feelings. It merely conveys "This is how I understand your feelings. Am I accurate?"

PGH SELF ASSESSMENT

1. What does each of the following letters stand for?

   E_____

   P_____

   S_____

   D_____

   T_____

2. True_____ or False_____: PGH includes only a few of the components of the federal EPSDT program.

3. In order to receive PGH services you must (check as many as apply):

   a. be a Medicaid recipient _____

   b. be under 6 years of age _____

   c. be under 21 years of age _____

   d. have a known illness or handicapping condition _____

   e. have not seen a doctor for one (1) year _____

4. What are the major differences that distinguish PGH from Medicaid? (Check as many as apply.)

   a. Periodicity _____

   b. Free treatment services _____

   c. Outreach and case management _____

   d. Long term care _____

   e. Preventive health care _____

   f. Health education _____

   g. Provider monitoring _____

5. True_____ or False_____: All Medicaid-certified physicians and clinics must provide PGH services.

6. True_____ or False_____: Children who need treatment services should be screened more often.

7. Which of the following are included in an EPSDT/PGH Assessment? (Check as many as apply.)
   a. Physical exam _____
   b. Hearing test _____
   c. Developmental assessment _____
   d. Medical history _____
   e. Immunization history and update _____
   f. Dental treatment _____
   g. Growth assessment _____
   h. Anemia screening _____
   i. Vision testing _____
   j. Lab tests _____
   k. Referral for further diagnosis and treatment of abnormalities _____

8. True_____ or False_____: Physicians must sign a contract to participate in PGH.

9. True_____ or False_____: Physicians who bill Medicaid for well-child examinations cannot participate in PGH.

10. The current fee for a EPSDT/PGH Assessment is (circle one):
   a. $12.50
   b. $26.00
   c. $26.50
   d. $22.00
   e. none of the above

11. To obtain payment for an EPSDT/PGH Assessment a physician must submit to DPW a copy of the (circle all applicable).
   a. EPSDT/PGH Claim Form
   b. EPSDT/PGH Medical Examination Report
   c. Both a and b

12. As of December, 1981, there were about _____ physicians participating in PGH throughout Massachusetts.

MARKETING CONCEPT

The marketing concept is

SEGMENTATION

- **Identify Market** (pool of potential providers)

  - physicians who provide primary care
  - pediatricians
  - internists
  - family practitioners
  - obstetricians/gynecologists

- **Segment Market** (otherwise market diversity makes communication inefficient)

  - specialty
  - location
  - type of practice
  - Medicaid participation
  - PGH participation*

PGH MARKET SEGMENTS

A. Physicians participating in PGH*

B. Primary care physicians currently participating in Medicaid but not PGH

C. Primary care physicians not participating in Medicaid or PGH in towns with low provider participation

D. Community Health Centers

PGH PROVIDER RECRUITMENT/RETENTION PROGRAM

I. Marketing Concept

The marketing concept is a management orientation that holds that the key task of the organization is to determine the needs and wants of target markets and to adapt the organization to deliver the desired satisfactions more effectively and efficiently than its competitors.

Definition: Marketing is the task of finding and securing consumers for a firm's output. Public agencies, like private firms must find, secure and retain customers. In the case of this project, Project Good Health is the organization trying to market a product, the PGH program, to physicians. In this case, physicians are the consumers to whom PGH is marketed.

II. Marketing Approach

A. Segmentation

1. Identify market (pool of potential providers)

a. Total market - physicians who provide primary care to people under 21 years of age

(1) Pediatricians

(2) Internists

(3) Family Practitioners

(4) Obstetrician/Gynecologists

2. Segment market - physicians are not a homogeneous mass. The entire group of physicians are too diverse to attempt to communicate to them as one group. It is neither efficient

nor effective to attempt to do so. Physicians can be segmented by:

a. Speciality

b. Location

c. Type of Practice

d. Medicaid Participation

e. Status

f. PGH Participation Status*

B. PGH Market Segments

1. Physicians participating in PGH*.

2. Primary care physicians currently participating in Medicaid but not in PGH.

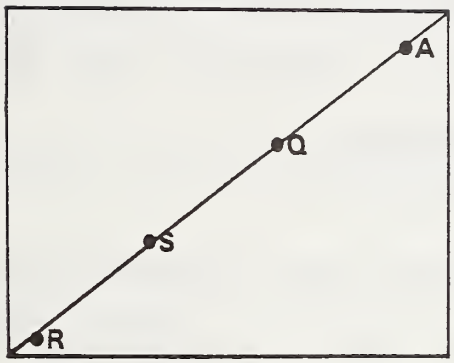
3. Primary care physicians not participating in Medicaid or PGH in towns with low provider participation.

4. Community Health Centers.

C. Targeting - By focusing on a single market segment or subsegment, the state can concentrate its resources more efficiently and effectively and demonstrate successes in a shorter period of time than by marketing to all segments at once. The first successes are essential for the decision to spread throughout the physician community.

AQSR

- Awareness
- Qualification
- Selection
- Retention



100%
Non-Personal

100% Personal

AQSR

(continued)

Awareness can be accomplished by non-personal techniques. Letters, invitations, display advertising, posters, etc. are all effective tools for creating awareness of a product.

Qualification requires more specialized information for the individuals who comprise the market to determine if they qualify, i.e., if the product is "for them."

Selection requires the individual to make a decision to "select," or purchase the product. This requires personalized information, often in the form of a personal selling campaign.

Retention,

RETENTION

- Essential, but often overlooked (of 140 PGH contracted doctors, only 100 remembered they signed up for it)

- Most cost effective component of recruitment

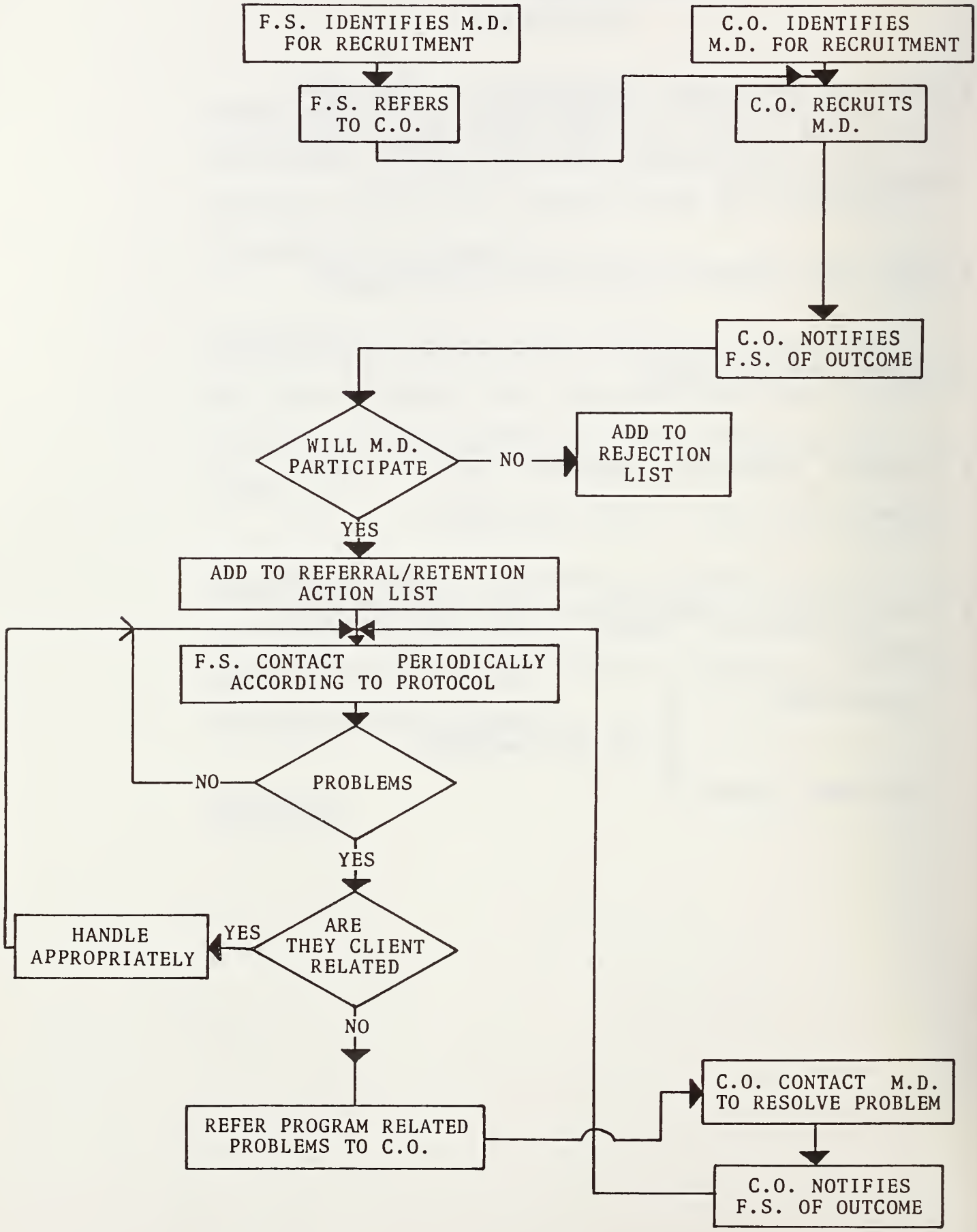
- Highest marginal value

- Personal approach necessary because each physician has had a unique experience

- Non-personal techniques can supplement personal
  - newsletter
  - periodic reports

  } provide feedback

PGH FIELD STAFF/CENTRAL OFFICE RECRUITMENT/RETENTION FLOW CHART



BENEFITS OF PROJECT GOOD HEALTH PROVIDER RETENTION/RECRUITMENT PROGRAM

Small Group Task:

(10 minutes) Discuss and list at least three benefits that could be the result of implementing the suggested Project Good Health (PGH) Provider Retention/Recruitment Program. You may wish to:

- Think of it from your own personal perspective and/or
- Think of it in relation to the total PGH program.

Select a reporter to share your group's list with the total group.

BENEFITS

1. More Physcians for Referral

2. High Retention

   - Less Initial Training
   - Fewer Problems

3. Easier to Satisfy Clients' Needs (by knowing more about the physicians)

Small Group Activity: Planning a Retention Program

1. Whom Do I Contact?
2. How Do I Contact Them?
3. When Do I Contact Them?

Situation: You are a PGH Field Staff person, assigned by your supervisor to participate in a Retention Program for PGH physicians. Over the course of one (1) year, it's your job to ensure that the three (3) physicians in your area continue participating in PGH.

Task: Design a Retention Program for the physicians in your area. For each physician identify:

1. how you will contact them (phone, personal visit and/or letter);
2. how many times per year you will contact each physician; and
3. who will participate in the contact (yourself, your supervisor and/or central office staff, others).

Constraints:

- Maximum number of personal visits per year per MD: 4
- Minimum number of personal visits per year per MD: 1
- Unlimited personal telephone calls, as needed
- Assistance from Central Office Provider Recruitment staff to participate in personal visits and telephone calls, as needed.

PHYSICIAN PROFILES

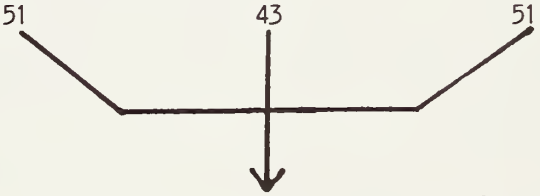
	Dr. Smith	Dr. King	Dr. Hogan
Length of Participation in PGH:	4 years	1 year	2 months
PGH Assessments Per Month	5	40	200
Type of Practice:	Solo	Partnership	Single specialty group
Location of Practice:	High Medicaid Population	Low Medicaid Population	Medium Medicaid Population
Number of Telephone Calls Per Year:			
Number of Personal Visits Per Year:			
Contact Team (Field Staff and/or Central Office):			

PHYSICIAN PROFILES

	Dr. Reagan	Dr. Carter	Dr. O'Neill
Length of Participation in PGH:	4 years	1 year	2 months
PGH Assessments Per Month	200	2	50
Type of Practice:	Community Health Center	Solo	Single Specialty, Group
Location of Practice:	High Medicaid Population	Low Medicaid Population	Medium Medicaid Population
Type of Contacts:			
Calls/Visits Per Year:			
Contact Team:			

Retention Call Schedule for PGH Field Staff

Profiles:	Segment I 80% of all screens/ 30 M.D.s	Segment II 15% of all screens/ 50 M.D.s	Segment III 5% of all screens/ 120 M.D.s	Total 100% of all screens/ (200 M.D.s)
Call Rate:	4 times/yr	2 times/yr	1 time/yr	
Calls/Year:	120	100	120	
PHONE				
Phones/Year:	120	100	120	
Hours/Phone:	1 hour	1 hour	1 hour	
Total Phone Hours:	120	100	120	
VISIT*				
Visits/Year:	96	80	96	
Hours/Visit:	3 hours	3 hours	3 hours	
Total Visit Hours:	288	240	288	
Total Hours:	408	340	408	
Total Days:	51	43	51	



Total Level of Effort Required to Service 200 Physicians: 145 days = 0.6 FTE per year

* Assumes 80% of those telephoned will request or require a personal visit.

RETENTION QUESTIONNAIRE

Please check the appropriate boxes to indicate how important the attribute is to you (VERY IMPORTANT, IMPORTANT, SLIGHTLY IMPORTANT, OR UNIMPORTANT) and how well the state PGH program's performance is in these areas (EXCELLENT, GOOD, FAIR, POOR).

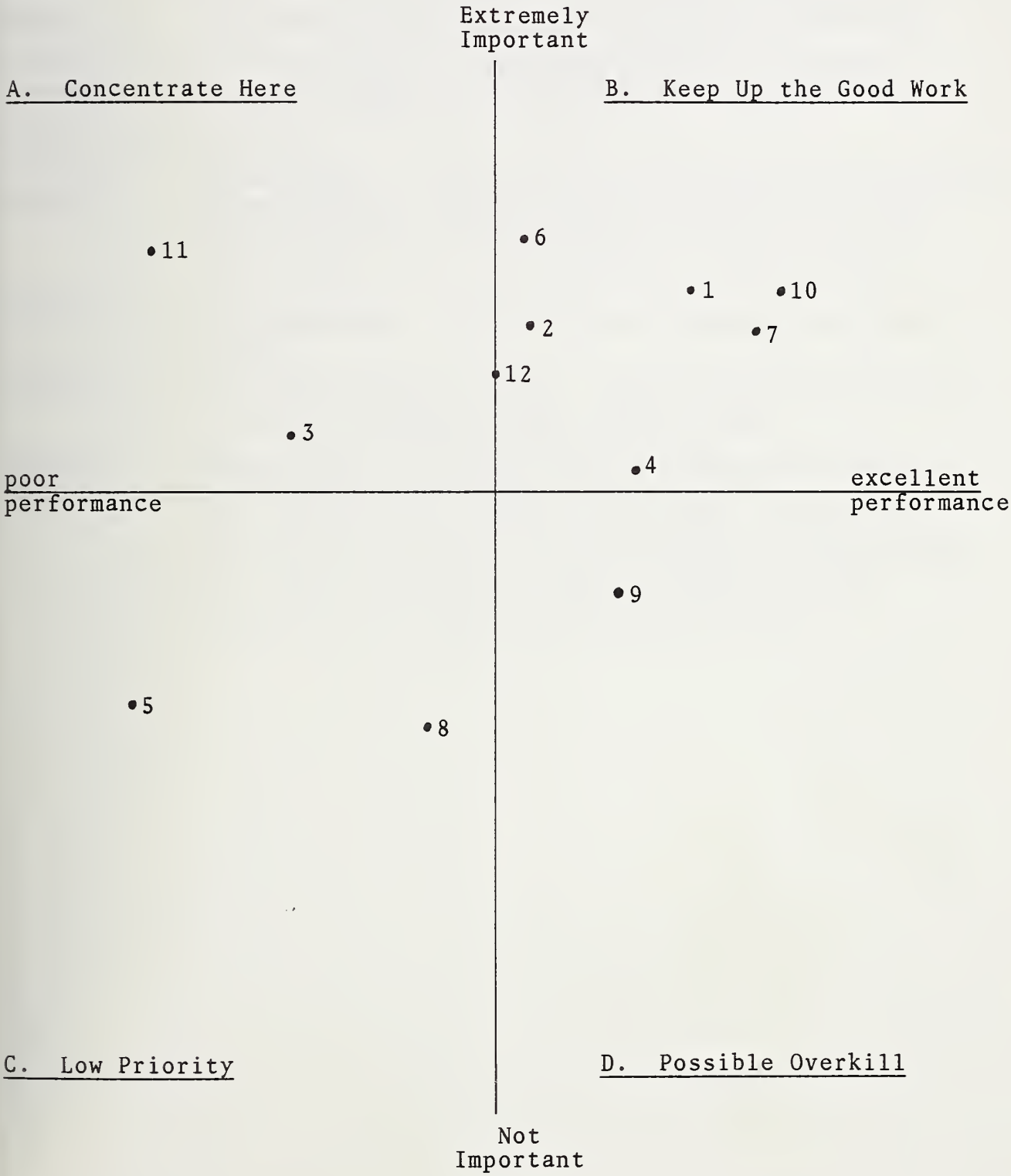
	IMPORTANCE				PERFORMANCE			
ATTRIBUTES OF PROJECT GOOD HEALTH	VERY IMPORTANT	IMPORTANT	SLIGHTLY IMPORTANT	UNIMPORTANT	EXCELLENT	GOOD	FAIR	POOR
1. State pays adequately for PGH health assessment.								
2. State pays promptly for PGH health assessment.								
3. Medicaid patients responsible for keeping appointments.								
4. State responds promptly to doctors' questions and complaints.								
5. PGH contributes to good health of Medicaid children.								
6. PGH regulations are clearly stated.								
7. State keeps doctors informed about program changes.								
8. State helps doctors find specialists for referrals.								
9. State channels children to doctors requesting more patient volume.								
10. Claims forms are clear, concise and easy to fill out.								
11. Medical Examination Reports are clear, concise and easy to fill out.								
12. Forms are available as needed.								

HYPOTHETICAL RETENTION QUESTIONNAIRE SUMMARY

Attribute Number	Description	Mean Importance Rating	Mean Performance Rating
1	Adequate Payment	3.2	3.0
2	Prompt Payment	3.4	2.1
3	Clients Keep Appointments	2.6	1.8
4	Quick Response to Problems	2.5	3.1
5	Contributer to Good Health	1.0	1.0
6	Clear Regulation	3.7	2.8
7	Prompt Information	3.4	3.5
8	Specialist Identification	1.2	2.8
9	Referrals for Higher Volume	1.8	3.0
10	Clear Claim Form	3.7	3.5
11	Clear MER Form	3.8	1.2
12	Forms Available	3.3	2.5

DISPLAY OF THE

RETENTION QUESTIONNAIRE



PROJECT GOOD HEALTH
RETENTION VISIT REPORT

After each Retention Visit, PGH Field Staff will complete a Retention Visit Report (RVR). The purposes of the RVR are (1) to provide Field Staff with documentation of the visit and (2) to communicate physician's perceptions of program strengths and weaknesses to Central Office for follow-up. The RVR has five (5) sections.

SECTION I. Physician Data. Record data on physician practice and productivity.

SECTION II. Program Problems. Identify physician perceptions of program problems which could impact unfavorably on physician participation in PGH.

SECTION III. Program Strengths. Identify physician perceptions of program strengths.

SECTION IV. Future Physician Participation. Identify physician's intentions to continue or discontinue participation in PGH.

SECTION V. Recommendations. Recommend actions for PGH staff to take to ensure continued participation of physicians in PGH (e.g., "Need personal visit by Central Office Staff to explain claims form," "revise referral box on MER," "increase number of retention visits per year from one (1) to two (2)").

PROJECT GOOD HEALTH
RETENTION VISIT REPORT

SECTION 1: PHYSICIAN DATA

Complete this section prior to the Retention Visit:

1.a. Physician Name(s):_____

_____

_____

1.b. Practice Location:_____

_____

_____

1.c. Medicaid Provider Number:_____

1.d. Date of Last PGH Visit:_____

1.e. Date of This Visit:_____

1.f. Number of PGH Assessments (per month):

At Time of Last Visit_____

Most Recent Month_____

SECTION 2: PROGRAM PROBLEMS

Following is a list of possible problems which physicians may experience with Project Good Health. Problems may be client-related (e.g.-high percentage of broken appointments by PGH clients) or non-client-related (e.g.-PGH Medical Examination Report is too lengthy). PGH Field Staff should explore these possible problem areas with physicians and their office staff at the time of the visit. Check all problems identified.

CLIENT

_____broken appointments
_____late for appointments
_____foreign language barrier
_____failure to obtain follow-up treatment from specialists
_____inability to confirm client's Medicaid eligibility
_____client "shops" among several different physicians
_____other_____

_____

_____

NON-CLIENT

_____claims rejected by DPW
_____claims paid too slowly
_____Medical Exam Report (MER) too long and detailed (specify problems)

_____

_____

_____inadequate information about PGH
_____Central Office staff are unresponsive to questions/problems
_____fear of Medicaid audit
_____delays for reporting lab results
_____other_____

SECTION 3: PROGRAM STRENGTHS

Following is a list of possible strengths of the PGH program, as seen by physicians and their staff. PGH Field Staff should explore these possible strengths with the physician at the time of the visit. Check all strengths identified.

_____Level of Reimbursement

_____Professional Responsibility to Serve the Poor

_____Professional Interest in Preventive Health Care

_____Other_____

_____

_____

SECTION 4: FUTURE PHYSICIAN PARTICIPATION

The estimated number of assessments the physician will provide over the next three (3) months will be:

_____about the same as now

_____about_____more assessments per month

_____about_____fewer assessments per month

The reasons for this increase or decrease in the estimated number of assessments are:_____

_____

_____

_____

_____

_____

SECTION 5: RECOMMENDATIONS

_____

_____

_____

_____

_____

_____

PROJECT GOOD HEALTH

RETENTION VISIT CHECKLIST

A. PARTICIPATION ISSUES

_____Reasons for Increase/Decrease in Number of Assessments

_____Reasons for Future Increase/Decrease in Number of Assessments

_____Intent to Continue/Discontinue

B. CLIENT ISSUES

_____Broken Appointments

_____Late for Appointments

_____Language Barriers

_____Failure to Follow-Up for RX

_____Inability to Confirm Medicaid Eligibility

_____Client "Shopping" for a Physician

C. NON-CLIENT ISSUES

_____Level of Reimbursement

_____Claims Rejected

_____Slow Claims Payment

_____MER Too Long and Detailed

_____Inadequate Information About PGH

_____State PGH Staff Unresponsive

_____Apprehension About Medicaid Audit

_____Delays for Receiving Lab Results

_____Commitment to Poor

_____Commitment/Interest in Preventive Care

_____Potential for High Volume of Patients

AN OBJECTIVE OF THE PROVIDER RETENTION/RECRUITMENT PROGRAM:

TO REDUCE 'DISSONANCE' ABOUT PGH THROUGH HEARING AND RESOLVING PROVIDER COMPLAINTS.

COMPLAINTS: THE TEN POINT SYSTEM

1. Permit the customer to tell his story without interruption.
2. Listen carefully.
3. Express regret.
4. Communicate that the company wants to be fair.
5. Talk about points on which there are agreement.
6. Get the facts!
7. Assign responsibility for the difficulty.
8. Take corrective action ASAP.
9. Educate to forestall future problems.
10. Follow-up to see that promised actions are taken.

From: Salesmanship, Pederson and Wright

PROJECT GOOD HEALTH SPECIALIST ROLE: CASE A

Time: February, 1982

You have been able to set up an appointment with two providers to discuss Project Good Health. Specifically, you want to check with them as to how things are going - are there any problems, what they are, and most importantly, to encourage these providers to continue providing Project Good Health services. You have never met this provider before and had a difficult time getting an appointment.

Case A - Dr. Goodfellow is a member of a group practice (5 physicians - Pediatrics/Obstetrics Gynecologists) with 80% of their clients receiving medical assistance. In reviewing information provided by the Central PGH Office, you notice a significant drop in billing from September to December. Because Goodfellow had been such a high provider you decided to make him your first contact as part of the PGH Provider Retention Program. You're a little anxious about the meeting because you've never done it before.

ROLE PLAY PROVIDER RETENTION ACTIVITIES CASE SITUATION A

Time: February, 1982

Physician's Role:

You are Dr. Goodfellow, from Massachusetts. You are a member of a group practice (5 physicians - Pediatrics/Obstetrics/Gynecologists). Approximately 80% of the people you see receive medical assistance. Until last summer, 1981, you had never participated in Project Good Health.

At that time a person from Project Good Health, you've forgotten the name, came to discuss the program and the possibility of becoming a PGH provider. After discussing it with your colleagues, you all agreed to provide PGH services and bill accordingly. Since you already were seeing so many medical assistance clients, the new reimbursement rate was the factor tipping you to participate. However, your support staff (Billing Clerk) was vehement about trying it out on a "test" basis and if any major problems occurred she would want the group to reconsider its decision.

Since that time you have run into the following problems:

1. Run out of billing forms in October.
2. Billing Clerk (Sylvia) has called five times with no success. You have gone back to your other procedure because a 3 month delay in forms with your high percentage of medical assistance clients and the long delay in payment anyway can't be maintained. Sylvia is frustrated and thinks the clinic shouldn't participate in PGH.

3. The number of No Shows has increased especially with pre-school aged children.
4. No one from PGH has been back in contact with you since July, 1981.

You agreed to a brief meeting today with Ms./Mr._____ a Project Good Health Specialist to discuss your problems.

* In your role play - feel free to add other details to make the "role" you play as realistic as possible.

PROJECT GOOD HEALTH SPECIALIST ROLE: CASE B

Time: February, 1982

You have been able to set up an appointment with Dr. Hassel to discuss Project Good Health. Specifically you want to communicate with him as to how things are going because this area has few Project Good Health providers and your clients have said positive things about Hassel.

You realize however from the conversations you had with his nurse that there are problems and a level of frustration. You found out that about 25% of his clients are receiving medical assistance.

This is your first Retention Visit and you are frightened.

ROLE PLAY PROVIDER RETENTION ACTIVITIES CASE SITUATION B

Time: February, 1982

Physician's Role:

You are Dr. Hassel, a 50 year old Pediatrician, practicing alone, in Worcester Massachusetts. Approximately 25% of your clients receive medical assistance. This has grown over the past few years. You're not terribly happy about it but the area where your practice is located is changing and many families have moved further away from you.

You have been a Project Good Health provider for 2 years. At the moment you and your staff are frustrated and damn angry about the problems you have in getting paid. Your nurse/receptionist has spent an incredible amount of time trying to get paid. Your claims keep getting rejected. She's called five times and written twice. Once someone called you back and assured you that the situation was being taken care of but you still haven't been paid. It is now 3 months since you've been paid.

You believe in the program and like the reimbursement rate but think the state is making it too complicated for you, as a small one-person office, to participate.

You have agreed, reluctantly, to meet with a Ms./Mr._____ of PGH but don't want to have your time wasted with a lot of promises and no action.

PROVIDER RETENTION VISIT ROLE PLAY OBSERVER GUIDE

Observe the Project Good Health specialist communicate in this role play.

1. Note examples of Active Listening: (Write down specifically what the person said that you felt was effective Active Listening.)

_____

_____

_____

_____

_____

2. List the specific things (behaviors or words spoken) the PGH specialist did that you felt made the situation an effective problem identification visit.

_____

_____

_____

_____

_____

3. List the specific behaviors that were not effective (words or actions).

_____

_____

_____

_____

_____

4. After the role play is finished complete the Retention Visit Report form based on the information you heard in the role play.

AN OBJECTIVE OF THE PROVIDER RETENTION/RECRUITMENT PROGRAM:

TO REDUCE 'DISSONANCE' ABOUT PGH THROUGH HEARING AND RESOLVING PROVIDER COMPLAINTS.

COMPLAINTS: THE TEN POINT SYSTEM

1. Permit the customer to tell his story without interruption.
2. Listen carefully.
3. Express regret.
4. Communicate that the company wants to be fair.
5. Talk about points on which there are agreement.
6. Get the facts!
7. Assign responsibility for the difficulty.
8. Take corrective action ASAP.
9. Educate to forestall future problems.
10. Follow-up to see that promised actions are taken.

From: Salesmanship, Pederson and Wright

TECHNIQUES FOR PGH SPECIALISTS TO IDENTIFY NEW POTENTIAL PGH PROVIDERS

1. Ask current satisfied providers for names of colleagues to contact.

2. Maintain contacts with AAP and other professional society representatives in area.

3. Become active in community and civic organization where high probability to meet doctors or office staff.

4. Examine various data resources, e.g. telephone directories, state publications.

5. Ask and listen to clients, friends and neighbors.

EVALUATION

Project Good Health Provider Retention/Recruitment

Training Seminar

February 16, 1982

	Excellent 5	4	3	2	Poor 1
1. The organization of the workshop was:					
2. The presentations were:					
a. Introduction & Overview					
b. PGH Provider Retention/ Recruitment Program					
c. Planning for Contacts					
d. How to Respond to Provider Problems					
e. Effective PGH Communication Process					
3. The group activities were:					
a. Warm-up activity: Active Listening					
b. PGH - Self-Assessment Discussion					
c. Small Group-List Benefits of Provider Retention Approach					
d. Small Group-Whom do I contact?					
e. Role Play: Provider Case Situations					
_____					

4. The key learnings for me were:

5. What I liked about the session was:

6. What I think should be changed is:

7. The applications to my job that I will make of material I learned today are:

8. Overall I would rate the session as:

_____ Excellent

_____ Very Good

_____ Good

_____ Fair

_____ Poor

APPENDIX C

EVALUATION OF PGH PERSONAL SELLING CAMPAIGN TO RECRUIT ACTIVE MEDICAID PHYSICIANS TO PARTICPATE IN PGH PROGRAM

A. EVALUATION QUESTIONS

Question # 1: Of those physicians personally recruited, how many expressed and interest in participating in PGH?

Question # 2: Of those physicians who expressed an interest in participating in PGH, how many did participate?

Question # 3: How did physicians who were personally recruited by by PGH staff evaluate the staff's performance in the recruitment visit?

B. PERSONAL SELLING CAMPAIGN

In May---July, 1981, Project Good Health staff conducted a personal selling campaign to recruit new physicians to deliver PGH health assessments. The campaign focused on the one hundred physicians in Massachusetts who provided the most well-child examinations in 1980 in the areas of greatest need for PGH services. About twenty-to-thirty additional Medicaid physicians were also recruited. PGH staff visited physicians in their offices throughout the state. Staff explained the benefits of PGH, recent changes in the program (elimination of contract, increased fee, reduced paperwork) and requirements for participation (completion of claims form and Medical Examination Report).

C. DATA

Data on the number and names of physicians recruited were obtained from lists provided by PGH recruitment staff. These lists also indicated physicians' interest or disinterest in participating, as identified by the staff at the time of personal visi ts. Participation data were reviewed for July-September, 1981. Also, a questionnaire was developed to obtain physicians' evaluations of staff performance. Because of contract constraints, it was not possible to distribute the questionnaire.

D. EVALUATION

Question # 1: Of 112 physicians recruited, 80 (71%) expressed an interest in participating in PGH.

Question # 2: Of 80 physicians who expressed an interest in participating, 40 (50%) provided at least one PGH assessment between July and September, 1981.

The table below shows a breakdown of physician recruitment, interest and participation by region.

REGION	RECRUITED*	INTERESTED*	PARTICIPATING (%)**	
Boston	8	8	7	(88%)
Springfield	21	17	8	(47%)
Worcester	11	3	2	(67%)
Lawrence	19	16	8	(50%)
Greater Boston	20	11	5	(46%)
New Bedford	33	25	10	(40%)
	112	80	40	(50%)

* May-June, 1981
** July-September, 1981

Question # 3: Attachment 1 is a Questionnaire which PGH could use to evaluate recruitment staff performance.

E. EVALUATION RESULTS

A rigorous evaluation of the PGH personal selling campaign would include:

1. evaluation of changes in PGH participation within a control group (unrecruited) of Medicaid physicians not previously participating in PGH;

2. evaluation of "brand loyalty"-- i.e., new physicians' continued participation in PGH after September, 1981;

3. implementation of the PGH Questionnaire to assess how important PGH staff visits were in convincing physicians to participate; and

4. other measures traditionally used in the sales field to evaluate sales force performance (see Attachment 1).

PGH staff should take these factors into consideration when planning future evaluations. However, based on the results shown in Section C, it appears that personal selling efforts have been fairly successful. Approximately one (1) in every three (3) physicians recruited, has participated in PGH. In sum, the additional forty (40) physicians represents a twenty-five percent (25%) increase in the number of participating physicians over July 1, 1981 (when 150 physicians were participating).

Attachment 1

PROJECT GOOD HEALTH
PHYSICIAN QUESTIONNAIRE

1. Are you aware that the regulations for Physician participation in PGH changed as of July 1, 1981? (circle one) Yes No

2. How did you and your office staff learn of the recent changes in PGH? (check one or more)

_____ letter from PGH

_____ telephone call from PGH

_____ personal visit from PGH

_____ meeting with PGH

_____ American Academy of Pediatrics

_____ colleague

_____ other _____

3. Has a PGH representative visited your office since July 1, 1981? (circle one) Yes No

4. If a PGH representative has visited your office, did she: (circle one)

schedule an appointment before arriving Yes No Don't Recall

explain the recent changes in PGH including:

- o higher reimbursement Yes No Don't Recall
- o elimination of PGH provider contract Yes No Don't Recall
- o provide you with written manual about the PGH program Yes No Don't Recall
- o demonstrate a thorough knowledge of the program Yes No Don't Recall
- o offer to train you and your billing staff on how to complete the new billing forms Yes No Don't Recall
- o ask you to participate in PGH Yes No Don't Recall

5. Did you agree to participate in PGH as a result of the meeting? (circle one) Yes No

6. Do you currently provide PGH services? (circle one) Yes No

7. Other comments about PGH? (on reverse)

Attachment 2

Measures of Sales Force Performance

QUANTITATIVE

INPUT MEASURES	OUTPUT MEASURES
o Personal Visits per Day	o Accounts: New, Lost
o Letters Written, Phone Calls Made per Day	o Volume: Assessments/Account, Assessments as Percent of Quota
	o New Accounts/Call

QUALITATIVE

- Personal Time Management
- Knowledge of Product, Policies, Customers
- Customer Relations
- Personality and Attitude

From: Management of the Sales Force,
Stanton and BusKirk, 1978

APPENDIX D

COMMON QUESTIONS TO EXPECT FROM PHYSICIANS AND SAMPLE RESPONSES

1. I already offer well-child care, but I bill Medicaid. Why should I participate in PGH?

   Doctor, through PGH the children are assured of appropriate follow-up care and reminders when they are due for their next exam. Plus, families can receive any added help they need like appointment scheduling and transportation. PGH even includes referral for services which are not covered under Medicaid. This exceeds the services children receive if you only bill Medicaid.

   Also, remember that by using the PGH form you will receive $26.50 rather than the $16.50 Medicaid pays for a well-child exam. For the _____ Medicaid eligible children in your practice this difference would represent a sizeable increase in your income without any additional work.

2. I wouldn't mind participating but I object to being asked to fill out the form. It's an usurpation of my professional judgement. Why doesn't the state trust me?

   I understand your concern about the form and the added work it represents. But we have worked very hard with the representatives of the Academy of Pediatrics to develop a form which will take the minimum amount of doctor's or nurse's time to complete and still give us enough information so we can deliver the follow-up services, periodic reminders, and other assistance which we promise to clients. We also must report information each month to the federal government which pays most of the money.

   So, our need for information does not reflect a lack of trust in our physicians. Rather, we need to efficiently manage the program and report to the federal government. Plus, the form only asks you to report about the outcome of the tests and procedures which are recommended by the AAP and which you are probably already doing. PGH really isn't intending to interfere with the way you practice medicine.

3. Why should I participate? What's in it for me?

First, starting July 1, the fee for a PGH exam will be $26.50. This is $10 more than you can receive from Medicaid for the same service. Furthermore, if you are interested, the PGH specialist in your area will add your name to the list of physicians who offer PGH. This can generate additional patients and be a way of building your practice.

4. I object to the state setting the Medicaid requirements rather than physicians. Why can't I do what I always do for the children in my practice?

Massachusetts has established a screening package and periodicity schedule as required by federal regulation. The regulation is intended to assure that all children requesting services will receive a similar complement of preventive and early detection measures.

The package and schedule Massachusetts adopted is the one which the American Academy of Pediatrics recommends. The state adopted the AAP recommendations to assure high quality care for the children and to be consistent with norms for practice in the state. It is likely that you are already providing the services covered under the PGH.

5. If I join does that mean that I have to take more Medicaid patients? I don't want my name on any list that will be used to send me more Medicaid patients.

If you agree to be a PGH provider you have several options regarding the number of Medicaid patients in your practice. Remember, you are in charge of your practice mix and the number of Medicaid patients in your practice is your decision. As a result of your agreeing to provide PGH services, your name will be placed on a provider resource list which the PGH specialist in your area will have.

If a PGH eligible client does call you for services, it is certainly your option not to increase your client load. You are not required, simply because a PGH eligible person calls you, to accept new patients. However, if you are accepting new patients in your practice, Massachusetts law prohibits discriminating on the basis of Medicaid eligibility. PGH does not have minimum or maximum requirements for the number of clients you see.

6. I like PGH and would like to see more children. Could you make sure that clients know that I offer these services?

If you agree to provide PGH services, we will place your name on the list of physicians who offer PGH in your area. This list will be given to any client who requests PGH and is in need of a physician.

If you would like to increase your practice size by seeing more Medicaid eligible children, the PGH specialist in your area, when giving the provider list to clients, can point out that your practice would be one where they could get an appointment quickly. However, you should know that a PGH specialist cannot tell patients that they should or should not choose any provider over the others.

APPENDIX E

FOCUS GROUP INTERVIEW GUIDE
(NOVEMBER 1981)

Time	Topic
3 Minutes	I. Introduction

- o Introductions -- first names
- o Establish time frame -- 1 - 1.5 hours
- o Discuss purpose -- listen
- o Discuss confidentiality (and need for tape recorders, reason for first names)

5 Minutes — II. Non-essential topic, warm-up case management site

- o Hear feelings about them
- o What do they know
- o Would they participate
- o Other comments

15 Minutes — III. Medicaid (if it hasn't come up already)

- o What areas do your patients come from?
- o What areas do your patients not come from?
- o How are the areas different?
- o How are the patients different?
- o What type of patients do you prefer to see?
  - By geographic area
  - By race and ethnic groups
  - By ages, e.g., infants, children, adolescents
- o Do your staff's attitudes differ from yours?
- o What mix of patients (medicaid/non medicaid) do you try to achieve?

10 Minutes — IV. Practice Preferences

- o What type of visits do you prefer (well child, acute care, very sick, etc.)?
- o What is your attitude about preventive health care?

45 Minutes — V. PGH

- o Who knows what the letters stand for?
- o Have you heard of it?
- o What have you heard?
- o Would you explain it to us?
- o Do you get paid?
- o Do you get paid enough?
- o What are your specific problems with it?
- o How would you change it if you were in charge?

INITIAL CONTACT PROTOCOL

PGH:
Hello. I'm_____ from the Department of Public Welfare, Project Good Health, May I speak to Dr._____?

Focal point:
Want to talk to the Doctor to get an appointment (goal)

Possible response:
I'm very sorry, she's with a patient right now. May I have your name and number and she'll get back to you?

(Assertiveness-to obtain specific information)

PGH:
I am going to be in and out of my office. Is there a particular time when Dr._____ is available to take calls? When are her first and last patients usually scheduled?

(Goal - to get an appointment)

Possible PGH response:
What I am interested in is meeting with Dr._____ to explain changes in Project Good Health, which I think will interest her.....Can you set up an appointment for me?

Possible responses:
Yes. (SET A DATE AND TIME)

No.

Success is also getting a specific time to call back.

PGH response:
Is there a time when it would be convenient for me to call her back. I'm in and out of my office and afraid I might miss her return call.

Possible responses:
Yes. (NOTE THE TIME AND CALL BACK THEN)

No.

Focus: Obtain specific information to reach goal of getting an appointment.

PGH response:
Since Project Good Health offers Dr._____ an opportunity to increase her income, and the Academy of Pediatrics now supports the PGH program, and major changes are occuring July 1st, I think it is important that I speak directly to Dr._____ about this.
What time is her first or last patient scheduled? Maybe I could stop in before she starts her day, or at the end of it?

Focus: Get an appointment to meet Doctor in her office.

PGH response to be put through immediately to the Doctor:
I'm _____, from Project Good Health. I'm calling to set up an appointment with you in your office to discuss the changes that have occurred in Project Good Health that will be of interest to you.
Because of significant changes, the Academy of Pediatrics has agreed to support PGH. Briefly, responding to physicians' recommendations, we have eliminated the contract, simplified billing and reporting, and increased the fee. Physicians will receive $26.50 for a PGH exam, rather than the usual $16.00.

Ask for appointment

When would it be convenient for me to come to your office?

APPENDIX F

PROJECT GOOD HEALTH

MARKETING APPROACH TO PROVIDER RECRUITMENT TRAINING PROGRAM

Community Health Foundation

Management Analysis Center, Inc.

February 19, 1982

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PROJECT GOOD HEALTH AGENDA

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MARKETING PRINCIPLES AND CONCEPTS

1. Marketing
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3. Marketing Orientation

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FOCUS GROUP PRACTICE SESSION

QUANTITATIVE TECHNIQUES

ACTION STRATEGY

KEY ISSUES

EVALUATION

PROJECT GOOD HEALTH

A MARKETING APPROACH TO PROVIDER RECRUITMENT

February 19, 1982

The Management Analysis Center
1100 Massachusetts Avenue
Cambridge, MA

Time		
8:45 - 9:15	Sharing of Objectives and Agenda Warm-Up Activity	Group
9:15 - 10:15	Marketing Principles and Concepts	Michael Blyth
10:15 - 10:30	BREAK	
10:30 - 11:30	PGH Marketing Approach	Michael Gelder
11:30 - 12:30	Marketing Technology Overview	Michael Blyth Joseph Liberatore
12:30 - 1:30	LUNCH	
1:30 - 2:30	Focus Group Role Play	Small Groups
2:30 - 2:45	BREAK	
2:45 - 3:15	Quantitative Techniques	Joseph Liberatore
3:15 - 4:15	Action Strategy - Media/Message - Retention Plan	Joseph Liberatore Michael Gelder
4:15 - 4:45	Key Issues - Marketing Management - Product Refomulation	Group
4:45 - 5:00	Summary & Evaluation	Group

OBJECTIVES

As a result of this conference, PGH staff will be able to:

1. Explain the principles of marketing and their relevance to PGH.
2. Discuss how the principles can be applied to the task of recruiting physicians.
3. Apply specific skills to designing and operating a marketing program for provider segments.

MARKETING PRINCIPLES AND CONCEPTS

This is a summary of a speech given by Karl Hellman of MAC. This speech was adapted by Michael Blyth for his presentation on Marketing Principles and Concepts.

1. MARKETING

Companies turn to marketing when faced by slow growth, increased competition, and turbulence in their environments. Marketing turns management's attention back to a fundamental truth: Successful companies succeed by designing, manufacturing, and marketing products that customers want and need, not by making products that the companies want to produce.

The history of business is full of examples of companies that ignored the basic truth of marketing to their own detriment and ultimate demise. Consider the case of the Baldwin Locomotive Company.

For 100 years, the Baldwin Company made the finest steam locomotives in the country. In the 1930s, the diesel locomotive was developed. It had a number of technological, efficiency, and operational advantages including instant start-up, greater fuel economy and range, greater starting acceleration, reduced servicing, costs and downtime, and superior cleanliness. Also, diesel locomotives could be hooked up in tandem and operated by a single crew whereas each steam locomotive had to have an engineer and fireman. General Motors, experienced in diesel technology, was also a leader in car, truck and bus businesses. It saw itself as a builder of transportation, regardless of the technology used, and was ready to recognize and respond to the ultimate economics of the railroad business.

Baldwin, with a massive investment in steam engine technology and a long and romantic history, could only think of itself as a steam locomotive builder. Baldwin did not respond to the need that the new diesel technology filled. Instead, it focused on making a better steam locomotive with more features and capabilities, none of which really addressed the fundamental shortcomings that steam had. Baldwin stayed in business as long as it did because of World War II, which froze nonmilitary technology, and because of railroad management's nostalgia and reluctance to switch from coal, which one of its biggest freight customers. Eventually, Baldwin could no longer sell the romance of steam against the economics of diesel, and after a few expensive failures with diesel and hybrid technologies its demise was rapid. It was out of business by the 1950s.

A marketing orientation would have alerted Baldwin to the real customer needs and the reasons why they were being served more efficiently by the new technology. It could have led Baldwin to an early and critical assessment of whether steam could meet those needs, and thus it would have warned them that they had to change to a better technology.

Each of us can think of examples of companies that have been put out of business because they were inattentive and unresponsive to technological changes that made their products obsolete. The Baldwin example is appropriate in industrial situations. Its response was typical. Many producers of industrial products routinely increase the engineering efforts that go into their products in response to competitive pressures, rather than question the basic technology.

It is interesting to look at companies that were driven out of business by revolutionary change. But in fact the more frequent and insidious problem for most companies is in keeping up with or anticipating evolutionary change, and therefore slipping slowly out of a competitive position without really understanding why until it is too late. For this purpose, it is more useful to look at those companies that seem to succeed in weathering stormy situations and even turn them to their advantage. The lesson usually learned is the value of a marketing orientation.

Companies that succeed are characterized by the way they do a number of things:

1. Awareness of customer needs.

Marketing does not necessarily say that the industrial customer is King. It does say that the customer's point of view is what defines the outputs and therefore should be the starting point for the company's efforts.

Successful companies continually examine customers' situations to understand their needs and then seek solutions to them.

2. Oriented to discovering wants

In the consumer environment, it is easy to go into the marketplace and ask people what they want, what they need, what they are willing to buy.

The industrial environment is more complicated. In many cases, customers not familiar with the vendor's technology and are not able to express their wants and needs. They may not able to express their willingness to pay for products which would solve their problems. Often they have become accustomed to a problem or they may have made a signicant investment in working around it. The definition of an industrial customers' needs is more complicated, but not impossible.

3. Anticipating trends

The most successful companies never allow themselves to believe that they know all the answers, and they make a conscious effort to reexamine their products on a regular basis to see how well they satisfy the customers evolving needs compared to competing products. Successful companies don't take current technology as the limit of methods available to solve customer problems. They apply known technologies in new ways and combinations, and they are always

at the innovative edge, pushing R&D to solve more complex customer problems. The successful company may even educate the marketplace to the use of more efficient methods and better technologies.

2. DEFINITION OF MARKETING

Customer Need

The definition of marketing begins with a page taken from consumer marketing but which is equally appropriate in the industrial environment. Customers do not buy products; they buy benefits. This is illustrated by 1/4" drill bit. No tool could be more basic than a 1/4" drill bit. Certainly people who buy bits are selecting a simple product. But customers are really buying 1/4" holes. In the industrial environment, the technologies available for the production of 1/4" holes extend well beyond the normal consumers ability to pay: 1/4" drill bits can be used, but so can punch presses, numerically controlled computer-based machinery, and even laser technology. The point is that the marketing-oriented company thinks about the function its product performs for the customer, not the product itself.

Benefit Segmentation

A second point of the definition of marketing is benefit segmentation. Not only do customer buy benefits rather than products, but different customers buy different benefits. Some people buy watches to tell time, some people buy watches for jewelery.

The Total Product

A third aspect of the definition of marketing focuses on the bundle of benefits which customers seek when they buy a product. This leads to consideration not only of the physical product but also of intangible aspects such as delivery, service, and even sales contact. The total package of benefits is called the "total product." In industrial marketing, it takes in all aspects of the relationship between the supplier company and the customer company which make up the set of benefits which the customer company seeks.

Like a puzzle, the total product is composed of interlocking pieces. The physical product and its other aspects have to be designed in such a way that each fits with the other to produce an integrated whole. It is that integrated whole which provides the complete set of benefits being purchased by the customer company. Two service components of the total product that should be discussed in an industrial context are delivery and sales engineering.

Delivery

Physical distribution is an often-overlooked component of the total product that the customer is buying. For an example, flexibility of delivery is one of the key factors of distribution. In some cases, flexible delivery may have little value to a customer, particularly when the product plays a predictable, stable role in the production process, and the customer is able to plan in advance when the product will be needed. Or timing of the product may not be critical to the production process, so the customer may be able to rearrange the process for delivery a month early or a month late. But with many industrial products, flexible delivery is essential. Requirements may be difficult or impossible to plan, yet the product must be at customer company's destination in time for its use. Thinking about flexibility of distribution aspects desired by the customer company leads to strategic consideration of channels of distribution best equipped to deliver the kind of distribution required by the customer.

In summary, marketing in the industrial environment rests on three principles:

1. Customers buy benefits, not products.

2. Customers can be segmented according to the particular benefits they seek.

3. The augmented product holds the benefits that customer companies seek.

3. MARKETING ORIENTATION

Having talked about the principles and trends that constitute the definition of industrial marketing, we turn next to understanding the characteristics of the marketing oriented company.

Everyone affects marketing in the marketing-oriented company, as a corollary to the concept of the total product, it is recognized that everyone within the company affects marketing. In a marketing-oriented company, everyone understands their impact on a benefit valued by the customer, making sure that they make their contribution effectively and efficiently toward the delivery of the total product.

Marketing and a Common Focus

Often companies fall into a pattern of having their different functions behave as if they were different kingdoms. Here we have four towers representing perhaps manufacturing, another engineering, marketing and finance. The first picture symbolizes the fact that each of the functions

considers itself separate and in conflict with the others. They are always looking warily at each other, making sure that they are maximizing the position of their own function with respect to the others. Even though this is not an ideal situation, this point of view may perhaps have had some value in the '60s when everything was growing very fast. Every function had to look out for itself to make sure that it could always have enough resources to hold up its end of the growth in a fast changing environment. It was possible for one function to find itself neglected unintentionally, in which case, the organization as a whole would suffer.

In the '70s and '80s, things have become much tougher. There are more outside threats and the opportunities are more difficult to see. Under these circumstances, it is important for the functions within the organization to cooperate.

In the second picture, marketing has helped to bring the common purpose of the organization into focus by showing how the functions work together to address customer needs. It has helped to draw a wall around all the towers to make one castle and all the functions are now focusing together on the enemy outside the gates - the competition. Marketing has helped to provide a common external focus for the entire organization to unify around.

The Entrepreneurial Spirit

As companies get bigger, they tend to lose the entrepreneurial spirit. Without it, they become vulnerable to others who are prepared to take risks and organize resources behind new ideas that satisfy customer needs better. The personal entrepreneurial style that a founder may have used to start the company many years ago is probably no longer appropriate. But an effective marketing department is the way to get all of the critical elements back together again.

PGH MARKETING APPROACH

PGH MARKETING APPROACH

- Literature Review
- Interviews
- Data Analysis
- General Methodology
  - Segments
  - Targets
  - Strategies

STRATEGIES

- Personal Selling Campaign
- Retention Program
- Research
  - Focus Panels
  - Questionnaires
    - Physician Survey - AAP
    - Retention - Performance Importance

RETENTION/RECRUITMENT PLANNING

A. Targeting

- Build on success -- Bell Cows
- Impact on goal
- Diffusion Theory

B. Planning

- Price
- Product
- Promotion
- Place (Distribution)

C. Programming (for each segment)

- Research
  - Qualitative
  - Primary -- interviews, focus panels
  - Secondary -- literature
  - Quantitative
- Trial Program
- Test (controls)
- Evaluate Program

SEGMENTATION

- **Identify Market** (pool of potential providers)

  - physicians who provide primary care
  - pediatricians
  - internists
  - family practitioners
  - obstetricians/gynecologists

- **Segment Market** (otherwise market diversity makes communication inefficient)

  - specialty
  - location
  - type of practice
  - Medicaid participation
  - PGH participation

PGH MARKET SEGMENTS

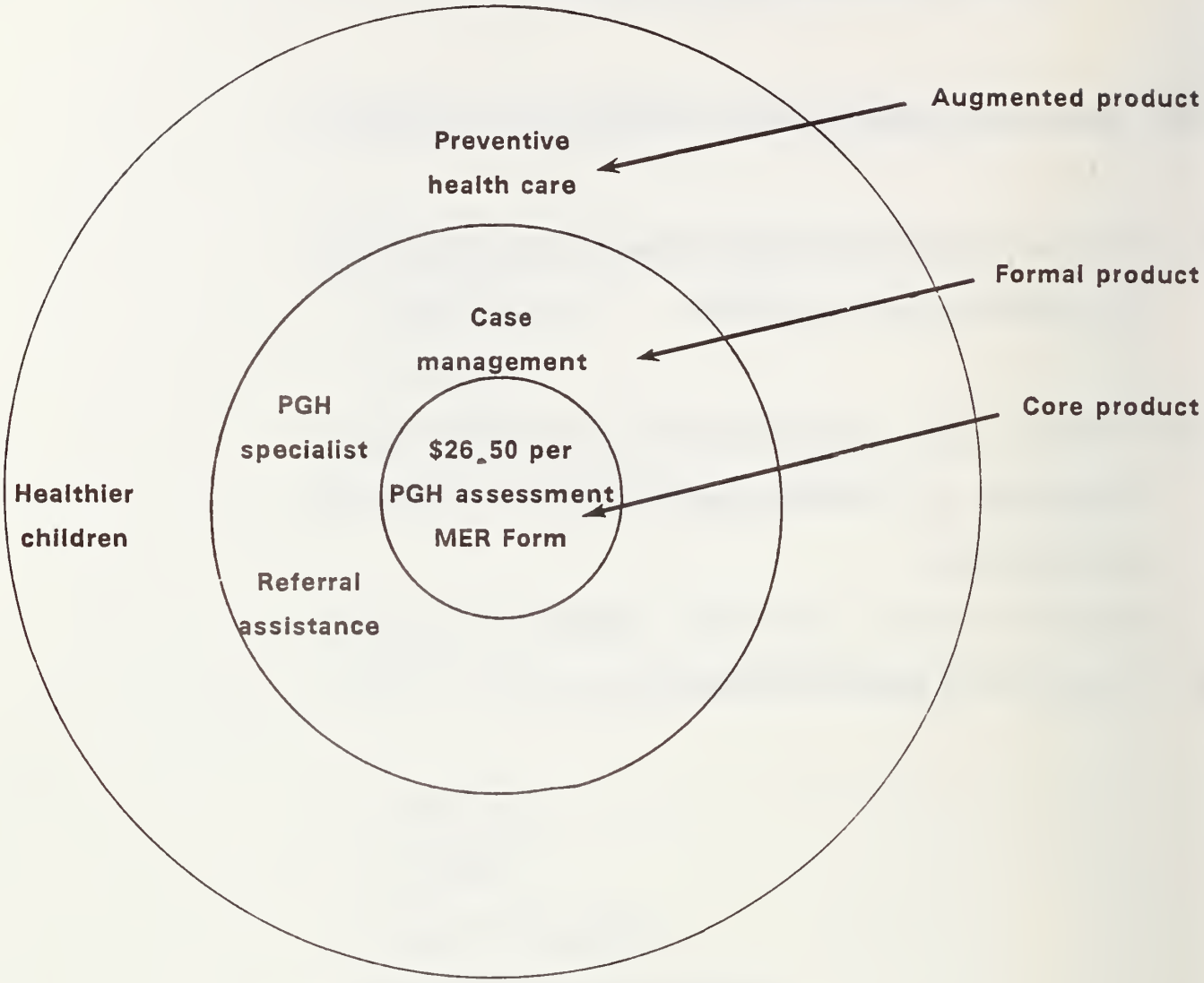
A. Physicians participating in PGH

B. Primary care physicians currently participating in Medicaid but not PGH

C. Primary care physicians not participating in Medicaid or PGH in towns with low provider participation

D. Community Health Centers

THREE LEVELS OF PRODUCT



MARKETING TECHNOLOGY OVERVIEW

FOCUS GROUPS

A. WHAT ARE FOCUS GROUPS?

B. WHAT ARE FOCUS GROUPS USED FOR?

C. HOW DO YOU CONDUCT FOCUS GROUPS?

D. WHAT ARE THE ADVANTAGES AND DISADVANTAGES OF FOCUS GROUPS?

A. WHAT ARE FOCUS GROUPS?

- Group depth interview
- Grew out of group therapy
- Based on concept of problem sharing
- Provides means of obtaining in-depth information
- Focused on specific topic
- Discussion group atmosphere
- Insights into individual behavior, thinking
- Not rigorously structured
- Encouragement of focused discussion

"A chance to experience a 'flesh and blood' consumer . . . to go into his or her life and relive all of the satisfactions, dissatisfactions, rewards, and frustrations that person experiences with the product at home . . ."

Although one of the most frequently used techniques:

- No book of rules
- No formulas
- No strategems

General Characteristics

- Usually with a homogeneous group
- 8 - 12 people
- 1-1/2 to 2 hours

B. WHAT ARE FOCUS GROUPS USED FOR?

1. Typical Applications

- Generate hypotheses that can be further tested quantitatively
- Generate information helpful in structuring questionnaire
- Provide overall background information on a product/service category
- Get impressions on a new product/service concept
- Stimulate new ideas about older products/services
- Generate ideas for creative new concepts
- Interpret previously obtained quantitative results

2. Types of People

- Computer engineers
- Personnel managers
- Heads of manufacturing companies
- Paper-making chemists
- Retailers
- Models
- Doctors
- Lawyers
- Salesmen
- Drug addicts

3. Case Examples

a. Alpha Power and Light

The Alpha Company had requested an electricity rate increase in its trading area for the first time in 20 years and wanted to know (1) customer opinions of the rate increase and (2) reasons for customer resistance to the rate increase, such as general service problems. Alpha Company was asking for a rate increase of 6%, which it felt was reasonable and necessary. The company planned to use the research results in its negotiations about price and for future advertising campaign ideas. Table 1 highlights the three stages of the marketing research process used in this research project.

The first stage of the research project was qualitative in nature. It was designed to identify where the company was at the present time in terms of perceived image of the company and degree of consumer dissatisfaction with rates and services, using the internal interview and audit process described in Table 1.

The information obtained in the first stage was used in guiding the researchers in the second stage of the research where focus group interview sessions were conducted. The focus group interviews were originally intended to obtain relevant information about the following questions:

1. Why were those consumers who opposed the rate hike really opposed?
2. What information should be communicated to those consumers opposed in order to justify a rate increase to them?
3. What reasons were given by those consumers not opposed to a rate increase?
4. How important were general service problems in influencing consumer opinions about a rate increase?

The focus group interviews uncovered a "rate bargaining" phenomenon among the groups which could be traced back to their fear of an energy shortage and the possibility of fast-rising prices for consumer goods and services. In general, consumers wanted assurances of available utilities and were willing to pay for these services, but they felt that price changes should be negotiated within a bargaining process. In addition, valuable advertising communication themes regarding consumer resistance to the rate increase were suggested by the interviews.

In the third stage of the research process, the hypotheses developed from the first two stages were quantitatively measured. A random telephone sample of 700 people was conducted in the company's trading area. Quantitative results were obtained about consumer attitudes toward service and rate issues, and alternative communicative ideas were evaluated for future advertising campaigns.

TABLE I

STAGES IN THE MARKETING RESEARCH PROCESS FOR ALPHA POWER AND LIGHT

Stage 1 (Qualitative)

Objectives

1. Identify past and current consumer complaints as to service problems and rate dissatisfaction
2. Identify perceived image of company as estimated by company employees
3. Evaluate past advertising and other materials communicated to consumers

Research Methodology

1. Personal interviews with company executives, complaint department employees, and field linemen
2. Audit of past records of consumer complaints
3. Audit of past company advertisements

Stage 2 (Qualitative)

Objectives

1. Evaluate consumer attitudes toward utility companies in this area generally
2. Develop hypotheses on the rate and service problems of customers
3. Develop psychographic profiles of respondents' attitudes about this company and this service
4. Identify specific topics for questionnaire construction

Research Methodology

1. Focus group interviews (12 groups of 10 persons in each group), each interview session videotaped
2. Short, self-administered questionnaire for all 120 persons

Stage 3 (Quantitative)

Objectives

1. Quantify existing consumer attitudes toward service and rate problems
2. Quantify existing consumer images of the company
3. Evaluate hypotheses about consumer attitudes
4. Develop communication ideas for future advertising campaigns

Research Methodology

1. Random sample of 700 adults using telephone interviews (100 interviews in each of 7 company districts)

b. Johnson Car Air Conditioning Filter

The Johnson Company developed a new filter to be used in car air conditioning systems. Management wanted to find out the feasibilty of the new product and develop a workable marketing plan. A two-stage research process was followed.

Focus group interviews were used in stage 1 to help develop hypotheses to identify potential markets, to determine advantages and disadvantages of the product from the consumer viewpoint, and to identify specific points for questionnaire design.

The focus group interviews indicated that families in which one or more members had allergy or respiratory problems might be the best prospects for the new product. Persons seriously concerned about air pollution were also identified as good potential buyers.

The major disadvantages of the product were the performance capability of the filter and the cost of replacement cartridges. Some individuals feared that the filter would cause their car's air conditioning system to malfunction. Nonallergic consumers expressed doubt about their need for the product. An unexpected resistance occurred when consumers were informed that the filter would need to be changed periodically.

After hearing the results of the focus group, the client wanted to proceed immediately with market introduction as a result of the findings that seemed favorable. On the advice of the research firm, the quantitative study in stage 2 of the research process was conducted. An analysis of 1,500 respondents in five cities showed that the original marketing strategy for introducing the new product was not economically feasible. This led to the development of an alternative marketing plan.

c. Harris Meat Company

The Harris Meat Company had declining sales of its luncheon meat wieners and franks in one region during the previous year and needed to identify and isolate reasons for the lack of sales growth. In this case, the focus group interviews exposed a serious packaging problem and minor problems in shelf space allocation and competitive pricing.

The packaging problem had extensive ramifications for the product's image, the ease of using the product, the quantity and quality of the shelf space exposure it received, and the consumer's decision to buy certain sizes of the product.

The interviews produced very clear hypotheses for explaining consumer behavior and brand penetration in particular market segments. Housewives in the focus groups explained clearly why the packaging was a problem to them.

Therefore, the quantitative study was narrowed to specific alternatives for improving the packaging strategy, communicating brand attributes, and increasing distribution penetration.

6. Accounting firm example

A public accounting firm wanted to develop a comprehensive marketing strategy. Focus groups were used to develop an understanding of the concerns of purchasers of accounting services. The results of the focus groups were used as major inputs in the construction of a questionnaire which would allow a more quantitative measurement of service needs and market segment opportunities.

Two sets of focus groups were held. The first set was brief sessions with Chief Financial Officers and Chief Executive Officers. These sessions were used to develop an understanding of the terminology that would be used in the second group of sessions and in the questionnaire. The second set of sessions involved executives in more detailed discussions. The object of these sessions was to uncover the service attributes of accounting firms with which they were most concerned. Each session allowed the participants to interact with one another in order to capture opinions and subjective evaluations which otherwise wouldn't be uncovered.

The results of all the sessions were then used to create a comprehensive, unambiguous questionnaire. Questionnaires were then sent to users of accounting services in suspected target markets. Returned questionnaires were used to construct a computerized data base. Analysis of the data base lead to the creation of detailed marketing plans for target markets.

C. HOW DO YOU CONDUCT FOCUS GROUPS?

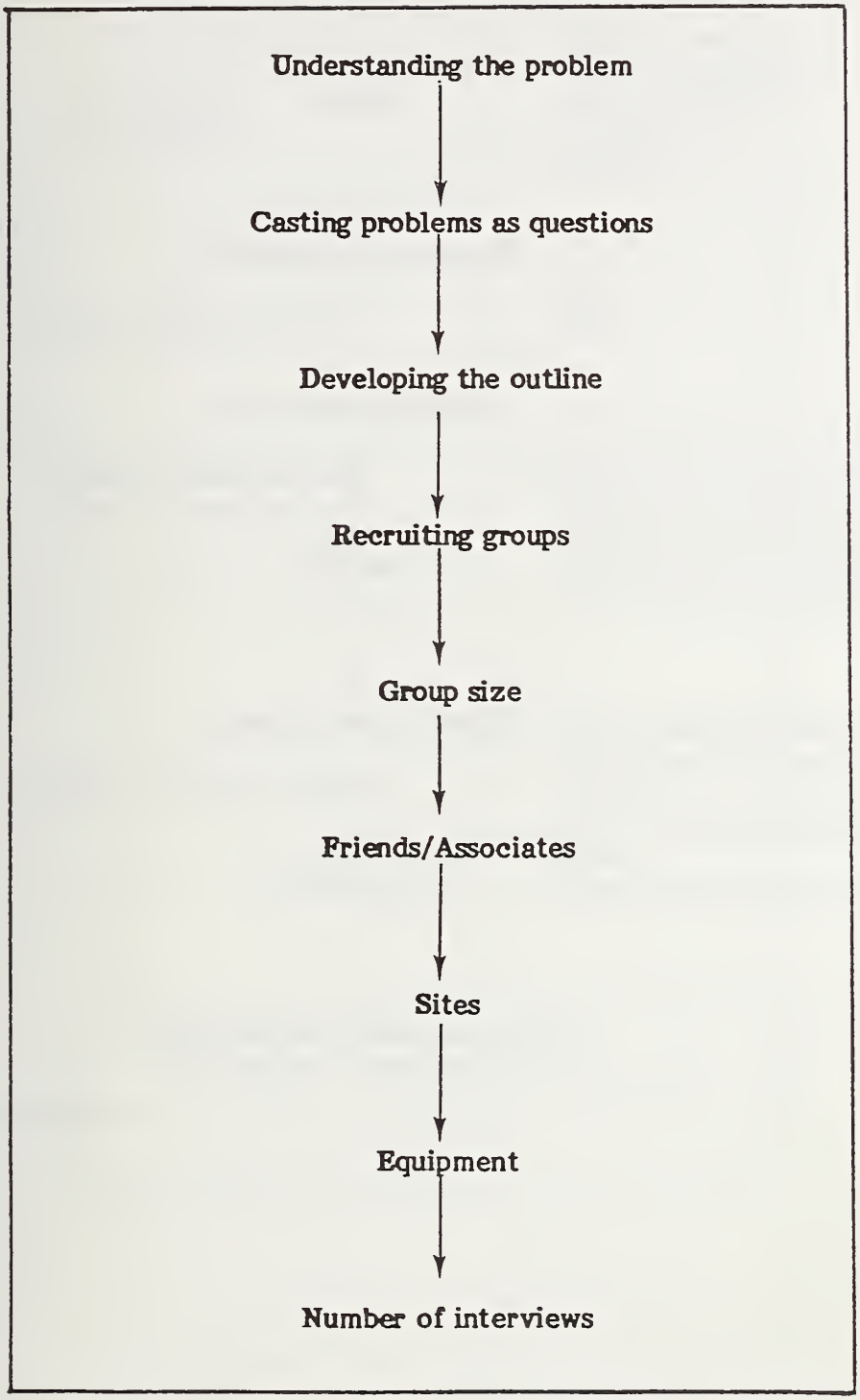
1. Preparation Steps

2. Interviewing

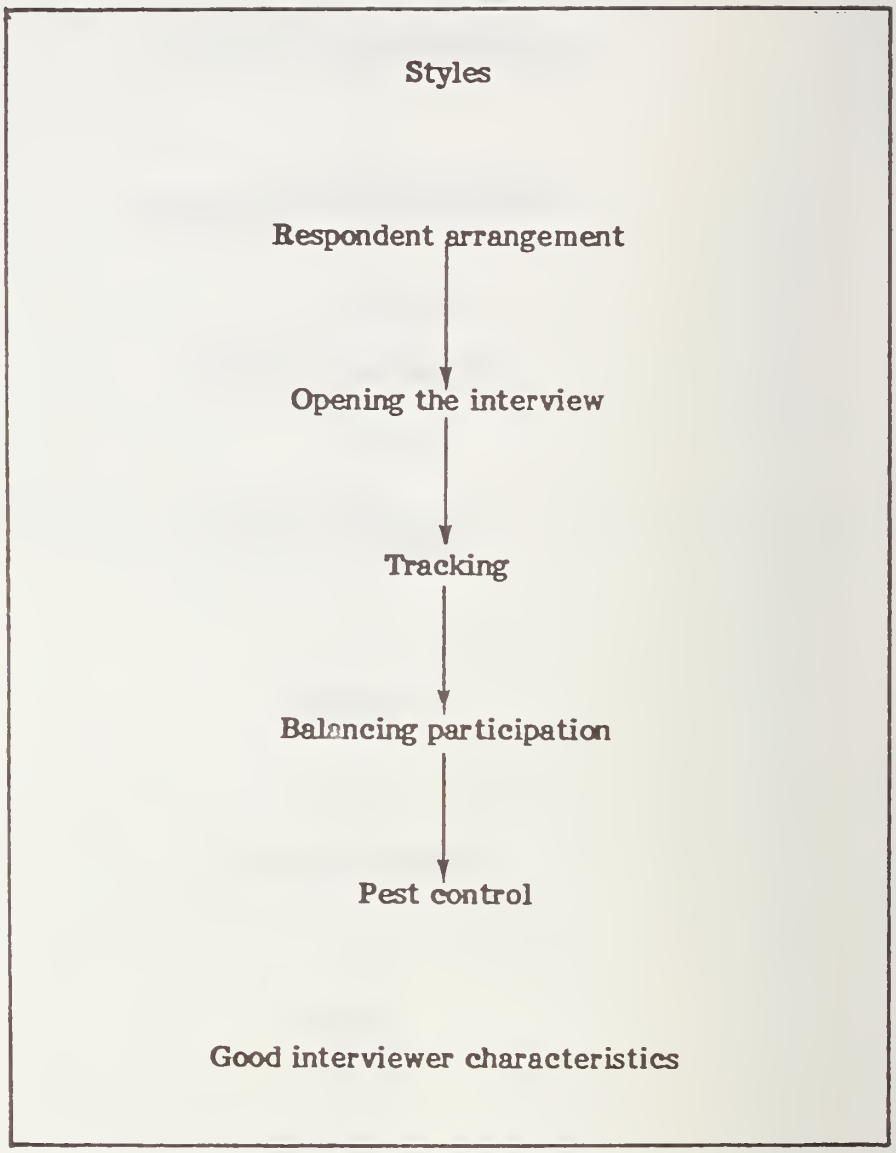
3. Analysis

4. Traps

1. Preparation Steps



2. Interviewing



3. Analysis

- **Report output is a function of**
  - Time
  - Cost constraints
  - Personal style
  - Client taste
  - End use
- **New product concept**
  - No
  - Yes

Complex issues require more in-depth analysis

- Listen, relisten to tapes
- Copy pregnant sentences into a general scheme
- Develop conclusions on fit with original hypotheses

- **Scissor-and-sort method**
  - Transcribe interviews
  - Edit, code, bracket key aspects
  - Code key aspects by subject area
  - Collate interviews by topic

KEY ISSUE - HOW SHOULD WE DO IT?

4. Traps

- Seduction - Are the data really hard?
- Newness - Is the concept so new that it falls out of the range of respondents' experience?
- Order/Effects - Does the issue order produce any inappropriate response influences?
- Delicate Topics - Are we getting into a personal area?
- Lack of Balance - Are we accepting negative as well as positive comments?

D. WHAT ARE THE ADVANTAGES AND DISADVANTAGES OF FOCUS GROUPS?

1. Advantages

- Combined group effort produces a wide range of data
- Random comments may set off chain reaction that furthers new ideas
- Group experience is exciting, stimulating
- Individuals may find comfort in the group and readily express ideas
- Spontaneity exists as all individuals are not required to answer
- Key items or concepts may be discussed
- Sessions may be analyzed in detail after interviews are completed
- Use of groups speeds up the interview process and data accumulation

2. Disadvantages

- Used as a cheap substitute as part of the "quick and dirty" syndrome
- Used as a support for preconceived, notions
- Don't indicate how extensive attitudes are
- Data are not always projectable
- Nonrepresentative interviewee samples
- Difficult to moderate
- At mercy of moderator experience
- Difficult to interpret results
- Need facilities that provide right atmosphere and results

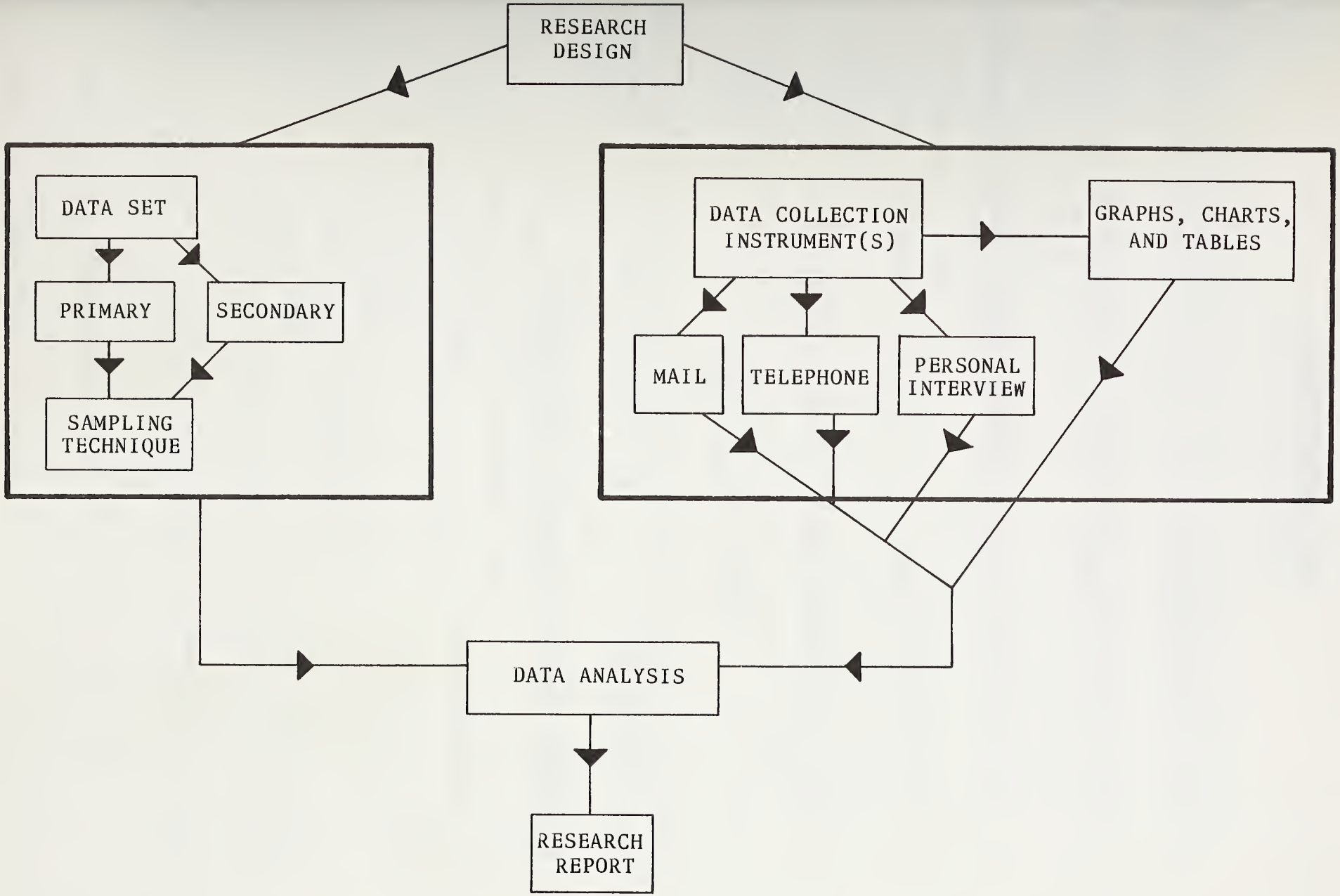
FOCUS GROUP PRACTICE SESSION

FOCUS GROUP ROLE PLAY

A. GENERAL TOPICS

B. PROJECT-SPECIFIC TOPICS

QUANTITATIVE TECHNIQUES


RESEARCH DESIGN
DATA SET
PRIMARY
SECONDARY
SAMPLING TECHNIQUE
DATA COLLECTION INSTRUMENT(S)
GRAPHS, CHARTS, AND TABLES
MAIL
TELEPHONE
PERSONAL INTERVIEW
DATA ANALYSIS
RESEARCH REPORT

QUESTIONNAIRE ISSUES

- HAS IT BEEN PRE-TESTED?
- IS THE QUESTION NECESSARY? HOW WILL IT BE USED?
- DO THE RESPONDENTS HAVE THE INFORMATION NEEDED TO ANSWER THE QUESTION?
- IS THE QUESTION BIASED?
- WILL THE RESPONDENTS OBJECT TO ANSWERING THE QUESTION?

PERSONAL INTERVIEW ISSUES

- TIME COMMITMENT
- MUTUALLY-AGREED EXPECTATIONS (VERBAL, WRITTEN)
- INTERVIEW GUIDE

PROJECT GOOD HEALTH
PHYSICIAN QUESTIONNAIRE

1. Are you aware that the regulations for Physician participation in PGH changed as of July 1, 1981? (circle one) Yes No

2. How did you and your office staff lear of the recent changes in PGH? (check one or more)
   _____letter from PGH
   _____telephone call from PGH
   _____personal visit from PGH
   _____meeting with PGH
   _____American Academy of Pediatrics
   _____colleague
   _____other_____

3. Has a PGH representative visited your office since July 1, 1981? (circle one) Yes No

4. If a PGH representative has visited your office, did she: (circle one)
   schedule an appointment before arriving Yes No Don't Recall
   explain the recent changes in PGH including:
   - higher reimbursement Yes No Don't Recall
   - elimination of PGH provider contract Yes No Don't Recall
   - provide you with written manual about the PGH program Yes No Don't Recall
   - demonstrate a thorough knowledge of the program Yes No Don't Recall
   - offer to train you and your billing staff on how to complete the new billing forms Yes No Don't Recall
   - ask you to participate in PGH Yes No Don't Recall

5. Did you agree to participate in PGH as a result of the meeting? (circle one). Yes No

6. Do you currently provide PGH services? (circle one) Yes No

7. Other comments about PGH? (on reverse)

PROJECT GOOD HEALTH
PHYSICIAN SURVEY

1. Do you currently participate in Project Good Health (PGH)? [Yes] [No]

2. If you currently participate in PGH, please identify the following factors as VERY IMPORTANT, IMPORTANT, SLIGHTLY IMPORTANT, or UNIMPORTANT in convincing you to participate.

	VERY IMPORTANT	IMPORTANT	SLIGHTLY IMPORTANT	UNIMPORTANT
PERSONAL VISIT OF PGH REPRESENTATIVE	_____	_____	_____	_____
ELIMINATION OF PGH PROVIDER CONTRACT	_____	_____	_____	_____
POSITION OF ACADEMY OF PEDIATRICS	_____	_____	_____	_____
INTEREST IN DELIVERING PREVENTIVE HEALTH CARE	_____	_____	_____	_____
HIGHER REIMBURSEMENT ($26.50/assess.)	_____	_____	_____	_____
PROFESSIONAL RESPONSIBILITY TO SERVE POOR CHILDREN	_____	_____	_____	_____
POTENTIAL FOR HIGHER VOLUME OF PATIENTS	_____	_____	_____	_____
FLEXIBILITY PROTOCOL FOR ASSESSMENTS	_____	_____	_____	_____

OTHER COMMENTS _____

_____

_____

3. If you do NOT currently participate in PGH, or if you participate but are dissatisfied with the program, please identify the following factors as VERY IMPORTANT, IMPORTANT, SLIGHTLY IMPORTANT, or UNIMPORTANT in convincing you NOT to participate (or in contributing to your dissatisfaction).

	VERY IMPORTANT	IMPORTANT	SLIGHTLY IMPORTANT	UNIMPORTANT
DON'T KNOW ENOUGH ABOUT PGH	_____	_____	_____	_____
REJECTED CLAIMS	_____	_____	_____	_____
LACK OF BILLING FORMS	_____	_____	_____	_____
TOO MUCH PAPERWORK	_____	_____	_____	_____
INADEQUATE FEES	_____	_____	_____	_____
DELAY IN REIMBURSEMENT	_____	_____	_____	_____
UNRESPONSIVE STATE PERSONNEL	_____	_____	_____	_____
POSITION OF ACADEMY OF PEDIATRICS	_____	_____	_____	_____
APPREHENSION ABOUT AUDIT BY MEDICAID	_____	_____	_____	_____
MEDICAID CLIENTS DIFFICULT TO SERVE	_____	_____	_____	_____

OTHER COMMENTS _____

4. How would you like to be informed about Project Good Health on a continuing basis? (Check one or more.)

____ Meeting/conference in your community sponsored by PGH.

____ Meeting/conference in your community sponsored by Academy of Pediatrics or other professional association.

____ Newsletter from State PGH.

____ Information from Academy of Pediatrics.

____ Periodic visits by local PGH Personnel.

____ Periodic telephone calls by PGH Personnel.

____ Other_____

_____

_____

5. Practice Information (this is necessary to better understand pediatrician's interests and needs which may differ according to practice situation):

a. Location of practice (city, town)_____

b. Type of practice (solo, group, clinic)_____

c. If group, number of physicians in group_____

d. Size of practice (number of patients)_____

e. Percent of practice pediatric_____

f. Percent of practice Medicaid_____

g. Number of PGH patients per month (current)_____

(anticipated)_____

(maximum)_____

6. Other comments about PGH?_____

_____

_____

_____

_____

7. Would you like more information about participating in Project Good Health?

Yes No

Do you want any specific information? _____

_____

Would you prefer to be informed by:

____ Mail

____ Telephone

____ Personal Visit to Your Office

Please write you name, address and telephone number in the space below for more information. (This will be forwarded to PGH.)

Name:_____

Address:_____

Telephone Number:_____

Best time to call:_____

SMALL GROUP EXERCISE
QUANTITATIVE STUDY DESIGN

Design a study to collect quantitative data to verify the qualitative data obtained in your focus panel discussion. On the attached sheet, identify:

SAMPLING UNIT: From whom will you collect data (e.g.-pediatricians, women, children, travel agents, chemists)?

SAMPLE STRATIFICATION: Will you stratify your sample by any independent variables, such as geography, age, sex, occupation or race?

SAMPLE DATA COLLECTION INSTRUMENTS: What instruments will you use to collect data: questionnaire (mail, telephone, personal interview, graphs and charts of secondary data or other)?

SAMPLE QUESTIONS: What questions will you ask your sample respondents?

QUANTITATIVE STUDY DESIGN

SAMPLE UNIT:

SAMPLE STRATIFICATION:

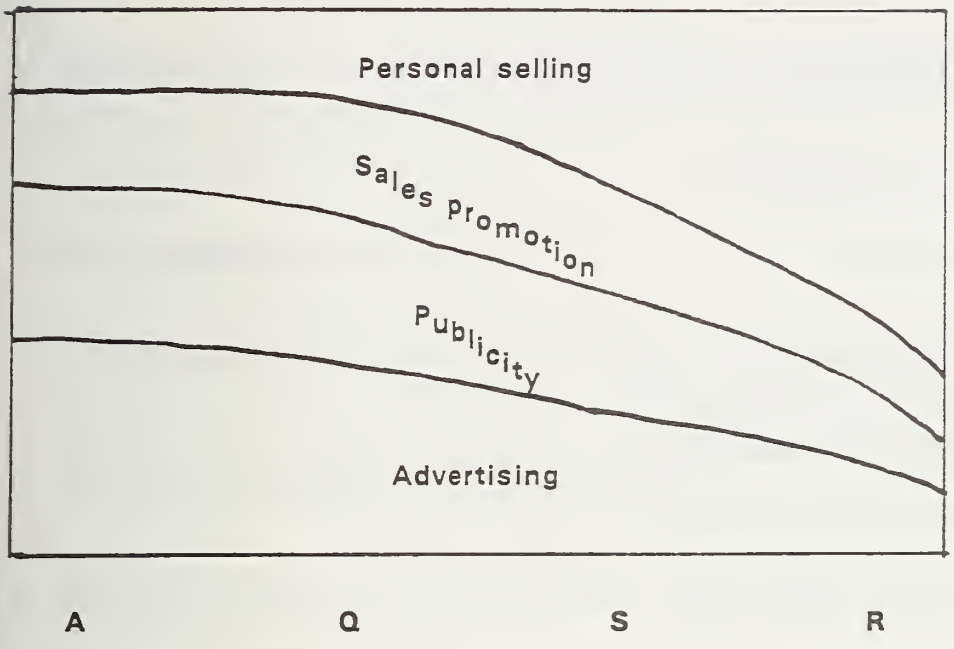
SAMPLE DATA COLLECTION INSTRUMENTS:

SAMPLE QUESTIONS:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

ACTION STRATEGY

COMMUNICATIONS MIX



THE MARKETING COMMUNICATIONS MIX

PERSONAL	NON-PERSONAL
o PERSONAL SELLING	o ADVERTISING
o PARTICIPANTS	o PROMOTION
o OPINION LEADERS	o PUBLICITY
o ACADEMY OF PEDIATRICS/ PROFESSIONAL SOCIEITIES	

PERSONAL

- PERSONAL SELLING CAMPAIGN

  Continued use of PGH staff as the primary communications medium between program and physicians.

- PARTICIPANTS/OPINION LEADERS

  Establishment of PGH Physician Advisory Board, composed of pediatricians, internists, family practitioners, CHC's and other PGH providers. The purpose is to provide on-going, policy advise to PGH programs and for the seven-to-ten members to meet bi-monthly.

- AMERICAN ACADEMY OF PEDIATRICS/OTHER PROFESSIONAL SOCIETIES

  Periodic consultation regarding provider-related issues. Use of 'PGH Column' in Academy/Society newsletter.

NON-PERSONAL

- ADVERTISING

  None, pending resolution of program problems regarding forms completion. Awareness is strong, already among physicians. If advertise, do so in professional journals, emphasize price and forms simplification.

- CONFERENCE/MEETING

  None, unlikely to be attended. Rather, 'buy time' at regularly-scheduled Academy meetings, Grand Rounds, etc.

- NEWSLETTER

  None, unlikely to be read.

- PROMOTION

  Target promotion to clients (children) rather than to physicians. Implement on selected basis. Ex: tickets to Boston Children's Museum.

- TRAINING SESSIONS

  For physician office staff, only. Hold in convenient regional locations, with use of audio/visual presentation.

- BROCHURE

  Simplify current brochure, reduce in size to four-page, toward providers.

DRAFT BUDGET : NEW PGH BROCHURE

BROCHURE: 3 color, 4 page, 3 photographs

TYPE SET/ PLATE	:	$ 850 - 900	(FIXED COST)
COPIES (800)	:	200	(VARIABLE COST)

TOTAL: $1,050- 1,100

DRAFT BUDGET FOR SALES PROMOTION :

TICKETS TO BOSTON CHILDREN'S MUSEUM

REGULAR ADMISSION: $ 3.75 ADULTS

2.75 CHILDREN

$ 6.50

TEST MARKET: 50 physicians, 20 admission packets (1 adult, 1 child) per physician)

= 1,000 admission packets

(x) $6.50

$6,500

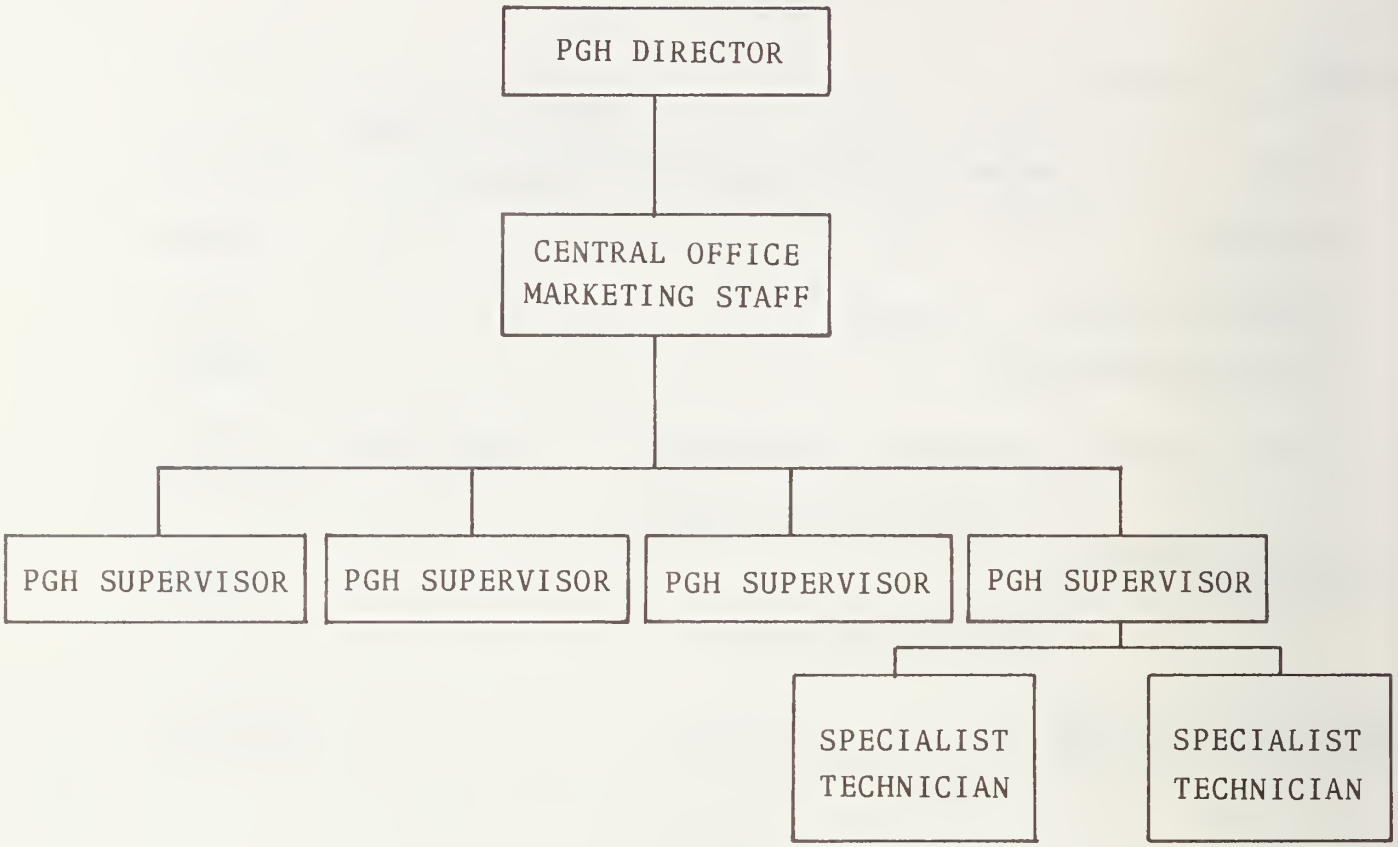
DISCOUNT (50%) : $3,250

DRAFT BUDGET FOR PGH ADVISORY BOARD

BUDGET PER MEETING

TRAVEL:	10 attendees (x) 22.5 ¢ per mile (x) 50 miles =	$112.50
ROOM RENT:		150.00
OVERHEAD PROJECTOR:		35.00
PRINTING AND MAILING:		100.00
		$ 397.50
SIX MEETINGS PER YEAR:		(x) 6
TOTAL BUDGET PER YEAR:		$2385.00

Project Good Health Marketing Network



THE SPECIFIC ROLE OF THE PGH SPECIALIST IN THE RECRUITMENT AND RETENTION PROGRAM

1. Identify new providers to be recruited (by central office).

2. Serve as the friend, ally of the physician regarding PGH.

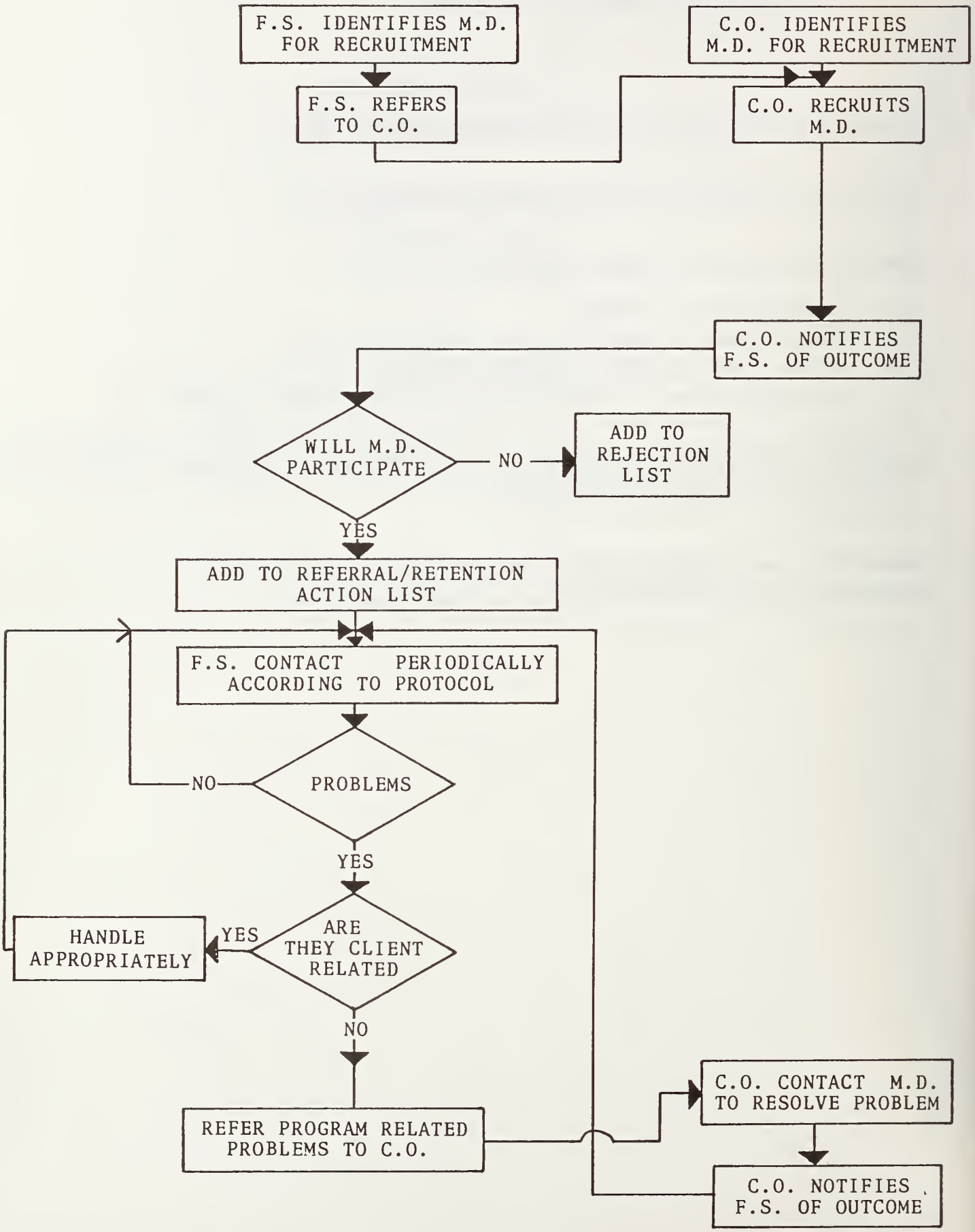
3. Serve physician specific needs including

   - listen to their problems
   - handle those relating to client issues such as no-shows, transportation, language assistance
   - refer the others to central office (billing, forms, payment)

4. Demonstrate to the physician how you use the information he or she provides on the MER for case management.

5. Communicate openly and frequently with appropriate central office personnel regarding physician status and problem resolution.

PGH FIELD STAFF/CENTRAL OFFICE RECRUITMENT/RETENTION FLOW CHART



2. Hypothetical Customer Service Program for PGH Field Staff

Profiles:	Segment I 80% of all screens/ 30 M.D.s	Segment II 15% of all screens/ 50 M.D.s	Segment III 5% of all screens/ 120 M.D.s	Total 100% of all screens/ (200 M.D.s)
Call Rate:	4 times/yr	2 times/yr	1 time/yr	
Calls/Year:	120	100	120	
PHONE				
Phones/Year:	120	100	120	
Hours/Phone:	1 hour	1 hour	1 hour	
Total Phone Hours:	120	100	120	
VISIT*				
Visits/Year:	96	80	96	
Hours/Visit:	3 hours	3 hours	3 hours	
Total Visit Hours:	288	240	288	
Total Hours:	408	340	408	
Total Days:	51	43	51	

Total Level of Effort Required to Service 200 Physicians: 145 days = 0.6 FTE per year

* Assumes 80% of those telephoned will request or require a personal visit.

AN OBJECTIVE OF THE PROVIDER RETENTION/RECRUITMENT PROGRAM:

TO REDUCE 'DISSONANCE' ABOUT PGH THROUGH HEARING AND RESOLVING PROVIDER COMPLAINTS.

COMPLAINTS: THE TEN POINT SYSTEM

1. Permit the customer to tell his story without interruption.
2. Listen carefully.
3. Express regret.
4. Communicate that the company wants to be fair.
5. Talk about points on which there are agreement.
6. Get the facts!
7. Assign responsibility for the difficulty.
8. Take corrective action ASAP.
9. Educate to forestall future problems.
10. Follow-up to see that promised actions are taken.

From: Salesmanship, Pederson and Wright

RETENTION QUESTIONNAIRE

Please check the appropriate boxes to indicate how important the attribute is to you (VERY IMPORTANT, IMPORTANT, SLIGHTLY IMPORTANT, OR UNIMPORTANT) and how well the state PGH program's performance is in these areas (EXCELLENT, GOOD, FAIR, POOR).

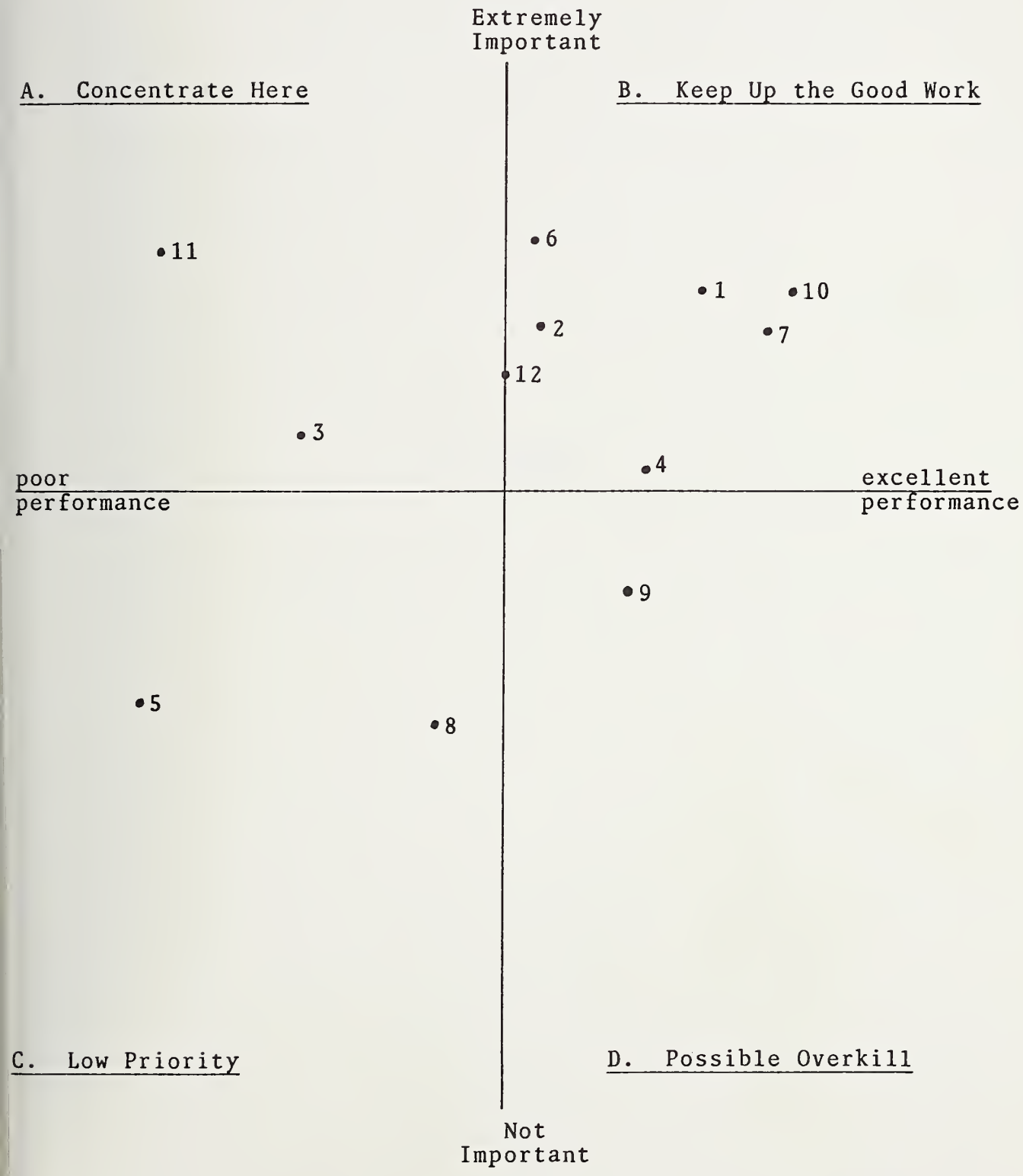
ATTRIBUTES OF PROJECT GOOD HEALTH	IMPORTANCE				PERFORMANCE			
	VERY IMPORTANT	IMPORTANT	SLIGHTLY IMPORTANT	UNIMPORTANT	EXCELLENT	GOOD	FAIR	POOR
1. State pays adequately for PGH health assessment.								
2. State pays promptly for PGH health assessment.								
3. Medicaid patients responsible for keeping appointments.								
4. State responds promptly to doctors' questions and complaints.								
5. PGH contributes to good health of Medicaid children.								
6. PGH regulations are clearly stated.								
7. State keeps doctors informed about program changes.								
8. State helps doctors find specialists for referrals.								
9. State channels children to doctors requesting more patient volume.								
10. Claims forms are clear, concise and easy to fill out.								
11. Medical Examination Reports are clear, concise and easy to fill out.								
12. Forms are available as needed.								

HYPOTHETICAL RETENTION QUESTIONNAIRE SUMMARY

Attribute Number	Description	Mean Importance Rating	Mean Performance Rating
1	Adequate Payment	3.2	3.0
2	Prompt Payment	3.4	2.1
3	Clients Keep Appointments	2.6	1.8
4	Quick Response to Problems	2.5	3.1
5	Contributer to Good Health	1.0	1.0
6	Clear Regulation	3.7	2.8
7	Prompt Information	3.4	3.5
8	Specialist Identification	1.2	2.8
9	Referrals for Higher Volume	1.8	3.0
10	Clear Claim Form	3.7	3.5
11	Clear MER Form	3.8	1.2
12	Forms Available	3.3	2.5

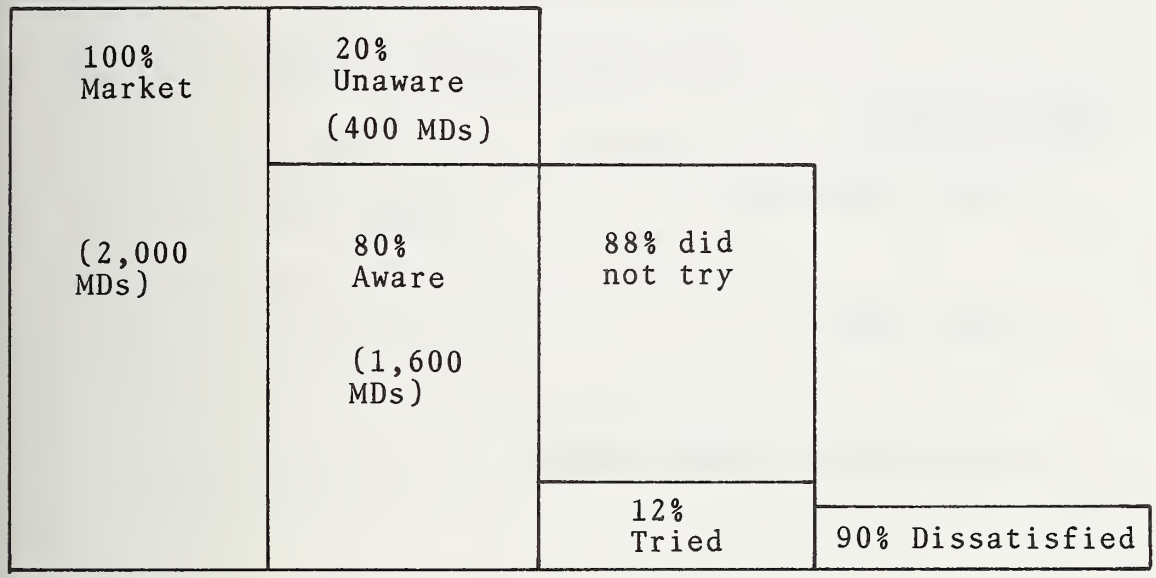
DISPLAY OF THE

RETENTION QUESTIONNAIRE



KEY ISSUES

PERCENTAGE DISTRIBUTION OF MARKET BY AWARENESS, TRIAL AND SATISFACTION



TOTAL AWARENESS TRIAL SATISFACTION

PERCENTAGE DISTRIBUTION OF MARKET BY AWARENESS, TRIAL AND SATISFACTION

(continued)

INDICATIONS

- High Awareness
- Few Trials
- Low Product Satisfaction

SOLUTIONS

- Product Redesign (MER Form)
- Sales Promotion Efforts
- Emphasize Retention

APPENDIX G

SUMMARY OF THE CHF/PGH PHYSICIAN MARKETING PLAN

MAJOR OBJECTIVES:

The Marketing Plan consists of the following major objectives:

- To identify potential PGH physicians, based on medical specialty, geographic location and previous participation in PGH and Medicaid.
- To identify geographic areas of greatest need for PGH services.
- To develop market segments.
- To select target segments for marketing.
- To develop marketing programs:
  - To encourage physicians to participate initially in PGH,
  - To encourage participating physicians to serve more PGH-eligible children, and
  - To maintain physician participation over time.
- To test, evaluate, and reconfigure marketing programs.
- To design and recommend a continuing plan for implementation and evaluation of the marketing programs.
- To prepare a training manual and train state PGH staff to implement and evaluate the Marketing Programs.

The major objectives presented above are outlined in more detail in the Worksteps below. The Worksteps are clustered around the four Market Segments.

WORKSTEPS/ACTIVITIES:

The following are the Worksteps for marketing programs for the four physician target segments.

The charts below identify each Workstep and the organization (CHF, PGH or both) responsible for completing the Workstep. Dates for completion of every Workstep are not provided. Since responsibility for completing many Worksteps lies with the state PGH program, the dates must still be negotiated. However, dates have been provided for those Worksteps initiated to date (February, 1982). Worksteps completed prior to the end of the contract are marked with an asterisk (*).

PGH MARKETING PROGRAM
WORKSTEPS

SEGMENT A: Primary Care Physicians participating in Project Good Health as of July 30, 1981

GOAL: To develop, implement and evaluate a Retention Program for PGH contract physicians.

NUMBER	WORKSTEP DESCRIPTION	ORGANIZATION RESPONSIBLE FOR COMPLETION
*A.1.	Interview PGH staff who personally contacted PGH physicians in recruitment effort conducted in April-May, 1981. (May 1981)	CHF
*A.2.	Develop a research instrument for PGH to determine the need and interests of physicians who are already participating in Project Good Health.	CHF
A.3.	Survey physicians to determine the amount and nature of contact they prefer to have with PGH field staff and central office personnel.	PGH/CHF
A.4.	Analyze results of survey and interview selected physicians in more detail if necessary.	PGH
A.5.	Develop procedures and protocols for field staff to follow in conducting recruitment efforts.	CHF/PGH
*A.6	Train PGH field staff on importance, value and skills necessary to conduct a retention program.	CHF
A.7.	Test various protocols and procedures in different regions in the state.	CHF
A.8.	Evaluate the tests by measuring the changes in physician participation and by comparing their participation with control groups.	PGH
A.9.	Restructure the retention program and restrain state PGH field staff based on the results of the evaluation.	PGH
A.10.	Organize provider advisory group to discuss program problems and changes periodically, and use groups as another medium to communicate with local physicians.	PGH

PGH MARKETING PROGRAM
WORKSTEPS

SEGMENT B: Primary care physicians who provide services to children under 21 years of age under the Massachusetts Medicaid program.

GOAL: To develop, implement and evaluate a PGH recruitment program for Segment B physicians.

NUMBER	WORKSTEP DESCRIPTION	ORGANIZATION RESPONSIBLE FOR COMPLETION
*B.1.	Interview physicians who have provided services to children under 21 through Medicaid. The purposes of this are (1) to identify their perception of Project Good Health's strengths and weaknesses relative to Medicaid and (2) to estimate their current level of awareness of Project Good Health and the changes that occurred in the program recently. (May-August 1981)	PGH
*B.2.	Identify towns with both high numbers of Medicaid eligible children and providers in those cities who have provided a large number of services through Medicaid. (May 1981)	CHF
*B.3.	Develop Qualification and Selection program. This will emphasize a personal selling campaign to recruit physicians in the communities identified. (May 1981)	CHF
*B.4.	Train PGH staff to conduct the personal selling campaign. Because of the state's immediate need to begin recruitment CHF developed and conducted this training program during May 1981. The training program included didactic and experiental components. The purpose was to prepare PGH personnel who had different levels of familiarity and interest in the program themselves to be effective sales people in the field. CHF training included lessons on identifying the providers, arranging an appointment, appropriate openings, content of materials covered during the meetings, appropriate closings and alternative responses depending on physician interest in the program. (May 1981)	CHF
*B.5.	Conduct personal selling programs. (June-August)	PGH
*B.6.	Evaluate results of central office staff efforts in B.5. (November-December 1981)	CHF
B.7.	Restructure program based on results of test.	PGH
B.8.	Retrain staff accordingly including field based PGH staff if necessary.	PGH

PGH MARKETING PROGRAM
WORKSTEPS

SEGMENT C: Physicians who do not participate in Medicaid and who practice in towns with relatively insufficient number of physicians providing primary care to children under 21 under Medicaid.

GOAL: To develop, implement and evaluate a PGH recruitment program for Segment C physicians.

NUMBER	WORKSTEP DESCRIPTION	ORGANIZATION RESPONSIBLE FOR COMPLETION
*C.1.	Identify Segment C physicians. To do so, CHF analyzed PGH physician participation and client eligibility data. Using these data, and estimates of physician caseload available to Medicaid recipients, CHF estimated that there are two regions of the state with a relatively insufficient number of primary care physicians currently serving Medicaid recipients. These regions are Springfield and Lawrence. (June 1981)	CHF
*C.2.	Convene two (2) focus groups of eight (8) to fifteen (15) Segment C physicians. One group covered in Springfield, one in Lawrence. To convene focus groups CHF contacted the director of the Massachusetts Academy of Pediatrics chapter and solicited names of contact people in these two communities. CHF then contacted the physicians recommended by the chairman and asked them to help arrange meetings with Segment C physicians. Focus groups were convened on November 10-11, 1981. (November 1981)	CHF
*C.3.	Develop a written survey questionnaire based of an analysis of focus panel results. The purpose of the survey is to gather quantitative information to confirm or modify qualitative information received from the focus panel. (December 1981)	CHF
*C.4.	Arrange with the Massachusetts Chapter of the American Academy of Pediatrics to distribute questionnaire to all academy members. (February 1982)	CHF/PGH
*C.5.	Distribute questionnaire. (February-March 1982)	PGH/AAP
C.6.	Analyze results and identify new physicians to be recruited and learn of programs strengths and weaknesses as perceived by the various physicians who responded.	PGH
C.7.	Develop new market sub-segments based on the physician practice data and responses to the questionnaire.	PGH

PGH MARKETING PROGRAM
WORKSTEPS

SEGMENT D: Community Health Centers

Goal: To develop, implement and evaluate a PGH recruitment program for Community Health Centers (CHC).

NUMBER	WORKSTEP DESCRIPTION	ORGANIZATION RESPONSIBLE FOR COMPLETION
*D.1	Conduct an assessment of current CHC participation in PGH. The assessment included personal contact with administrator of each CHC to determine (a) whether or not the CHC was intending to participate in PGH and (b) what problems the CHC's see in participating in the program. As a result of the assessment, three (3) groups of CHC's were identified: Group I: Intend to participate Group II: Intend not to participate Group III: Intend not to participate for a variety of programmatic reasons not related to computerized billing. (October 1981)	PGH/CHF
D.2.	Conduct marketing programs for each group. The emphasis will be on product redesign to accomodate to CHC's needs for automated reporting and billing parameters.	PGH
D.3.	Identify issues pertinent to computerized billing and develop action plan to involve CHC's with computerized billing in PGH.	PGH
D.4.1.	Convene meeting of Group III centers to discuss issues pertinent to non-participation.	PGH
D.4.2	Analyze results of the meeting and discuss with state PGH staff.	PGH
D.4.3.	Develop a recruitment/retention program for Group III centers.	PGH

Submitted to:
Gloria Moore, Project Officer
Child Health Staff, Office of Standards and Performance Evaluation
Bureau of Program Operations, Health Care Financing Administration
U. S. Department of Health and Human Services

REVIEW OF LITERATURE
ON
PHYSICIAN PARTICIPATION IN EPSDT/MEDICAID

November 1981

Submitted by:
Community Health Foundation
2650 Ridge Avenue
Evanston, Illinois 60201

under

Contract number HCFA-500-80-0082

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SECTION I

INTRODUCTION

The Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program has been beset with problems since its passage in 1967. As an extension of Medicaid, EPSDT is intended to assure that the 11 million infants, children and young adults under the age of 21 who are eligible for their states' Medicaid program receive periodic health assessments and needed diagnosis and treatment. Nevertheless, 13 years after the program became law, only 20% of the eligible population receive the intended services through EPSDT.

Shortage of physicians, dentists and other medical providers of EPSDT is one of the program's major deficiencies and helps to explain its limited success. The EPSDT law did not establish any new service delivery mechanism, nor did it appropriate any funds for establishing new health delivery resources. Instead, it placed responsibility on states to arrange for the care of children desiring the services. In effect, the law assumed the existence of a provider network to which families requesting EPSDT could be readily referred.

Unfortunately, one of the lessons of the past decade of EPSDT experience is that there is no such nationwide network of providers of health care to children available and accessible to the Medicaid eligible population. Because of this, some states have relied exclusively on local health departments for screening; others orient their program to private physicians, while others encourage the participation of both private and public providers. As the following sections illustrate, very few states relying on the private sector have been successful in recruiting enough physicians to meet the potential demand for services. The physician shortage has caused some states

to curtail their outreach to avoid encouraging more requests for services than the state can satisfy. Thus, a vicious circle begins, which helps to explain the low program utilization.

Yet the problem of insufficient physicians may not be overwhelming. Certain states have succeeded in enlisting adequate physician support. Other states have succeeded for a while, but then witnessed the attrition of many who were initially recruited. Other government programs, such as Medicaid and the National Health Service Corps, and private programs like Blue Shield, recruit providers. Drug and medical supply companies have also gained considerable experience in influencing the behavior of physicians. The science of marketing as applied to drugs, supplies, clinics and hospitals has developed rapidly since EPSDT began. There may be much to learn from the successes in designing, developing and selling products and services in the health field.

The purpose of this literature review is to learn whatever lessons there are from previous EPSDT experiences as well as from the experience of other public and private programs and organizations. A systematic marketing approach has never been applied to the task of recruiting physicians. This literature review is the first step toward identifying the barriers and potential incentives, and developing innovative tools and techniques that will lead to increased participation by providers and greater utilization by the clients for whom the program is intended.

SECTION II

PHYSICIAN PARTICIPATION IN MEDICAID AND EPSDT

DATA ON PROVIDER PARTICIPATION IN MEDICAID

Since EPSDT is one component of the Title XIX Medicaid program, the two are administered similarly in many states. Given the administrative overlap of the two programs, the problems and successes of one are commonly the problems and successes of the other. This is particularly true of provider participation.

When the Medicaid program first became law in 1965, health care policymakers and program administrators recognized the crucial role of provider participation in assuring Medicaid eligibles access to services. The Handbook of Public Assistance Administration, Supplement D (1966) defined this role as follows:

> Participating practitioners include sufficient members of each profession, and a proportionate number of practitioners qualifying for speciality practice within professions, so that the items of medical care and services included in the plan are available to eligible persons at least to the extent they are available to the general population. As a minimum, the participation ratio determined for each profession, and for specialties within a profession, should be approximately two-thirds of such practitioners in the state. (148)

These early guidelines reflected the interest of program administrators in providing the low income population with adequate access to medical care. The recommendation that two-thirds of the state's providers participate was an admittedly crude indicator of access. It did, however, convey the intent of Medicaid and provided a guideline for assessing the adequacy of the level of provider participation.

Current Medicaid and EPSDT regulations include no specific ratio for evaluating the adequacy of provider participation. Instead, state Medicaid plans are only generally required to assure high quality care (52 CFR 440.260)

on a statewide basis (52 CFR 431.50) with payment sufficient to enlist enough providers so that services are available to recipients at least to the extent that identical services are available to the general population (52 CFR 447.204). States are not required to report provider participation levels to federal Medicaid administrators, nor are there special penalties for low participation levels. As a result, data have not been systematically collected and neither trend nor cross sectional data on provider participation in Medicaid/EPSDT are available from federal sources.

For these reasons most studies about provider participation levels are anecdotal. The literature documenting Medicaid's early years indicates some unwillingness among physicians to participate in the program, although the findings are not supported by systematic data. (14,126) One 1968 Medicaid program evaluation identified 14 states reporting unwillingness of physicians or other providers to participate. (128) More recent literature includes a small number of studies of physician participation in Medicaid. Most of these studies similarly describe levels of physician participation in Medicaid and of the problems physicians encounter in serving Medicaid patients. (9, 53, 60, 61, 62, 72, 84, 121)

Davidson and Perloff have reviewed nearly all of the existing studies of physician participation in Medicaid. (146) Their findings are summarized in Table 1. Their discussion of the Table indicates several sources of diversity; the unit of observation (i.e., state, substate, physician) differs from study to study, as well as the definition of what constitutes participation. On the issue of participation the authors note that researchers define "participation" in a variety of different ways, including:

> The simple dichotomous "serves Medicaid patients - does not serve Medicaid patients" (9, 61, 72, 84, 121), the same dichotomy, but with the application of a lower limit screen which counts as not participating those physicians who see less than ten Medicaid patients per

quarter (60), another dichotomous measure "accepts new Medicaid patients - does not accept new Medicaid patients" (61, 121), "Medicaid patients or visits per physician" (60, 72, 121), and "services rendered per Medicaid patients. (60)

The manner in which participation is measured may influence one's perception of the participation problem. For example, simply counting whether or not physicians participate may give an inflated view of participation because the physician who sees only one or two Medicaid patients per year is said to "participate." In addition, so many different measures of participation are used that it is very difficult to make meaningful comparisons across studies.

A recent study by Mitchell and Cromwell analyzing so-called "Medicaid Mills" presents more carefully defined participation data compiled by the National Opinion Research Center in 1977. (98) In a national survey of nearly 4,000 physicians in private practice, drawn from 15 specialities, physicians were asked: "About what percentage of your patients have Medicaid?" This percentage was assumed to reflect the share of physicians' time devoted to Medicaid patients. The survey found that nearly one-fourth of the sample does not treat Medicaid patients at all. Another fourth reported that less than 10 percent of their patients receive Medicaid. The mean was 12.7 percent. Approximately 14 percent have larger Medicaid Practices (LMPs), in which more than 30 percent of their patients receive Medicaid. This distribution is presented in Figure 1. As this Figure illustrates, three-quarters of sample physicians care for only one quarter of the total Medicaid population. Almost one-third of all Medicaid patients, on the other hand, are treated by 5 percent of the physicians. Thus a small number of physicians appear to have assumed responsibility for a large proportion of the nation's poor, giving rise to the spectre of "Medicaid Mills." (98)

TABLE 1

Participation Measures and Observed Levels of Participation: Prior Studies

STUDY	DATA SOURCE	YEAR	PARTICIPATION MEASURE	OBSERVED LEVEL
Applied Management Sciences, 1975 (9)				
Connecticut	Medicaid claims	1973	percentage of state's	43%
Indiana	Medicaid claims	1973	physician population	58%
New Jersey	Medicaid claims	1973	billing Medicaid	49%
Hadley, 1978 (60)				
California	Medicaid claims	1972-75	Proportion of county physicians treating more than 10 Medicaid patients per quarter*	42%
			Medicaid patients per participating physician, given at least 10 patients*	52.9%
			Total number of services per Medicaid patient for participating physicians*	48.2%
Held, Manheim & Wooldridge, 1978 (61)	National probability sample, survey	1975	Average proportion of patient loads in area under Medicaid* (General/Family Practice)	15.1%
			Internal Medicine	10.5%
			Pediatrics	15.6%

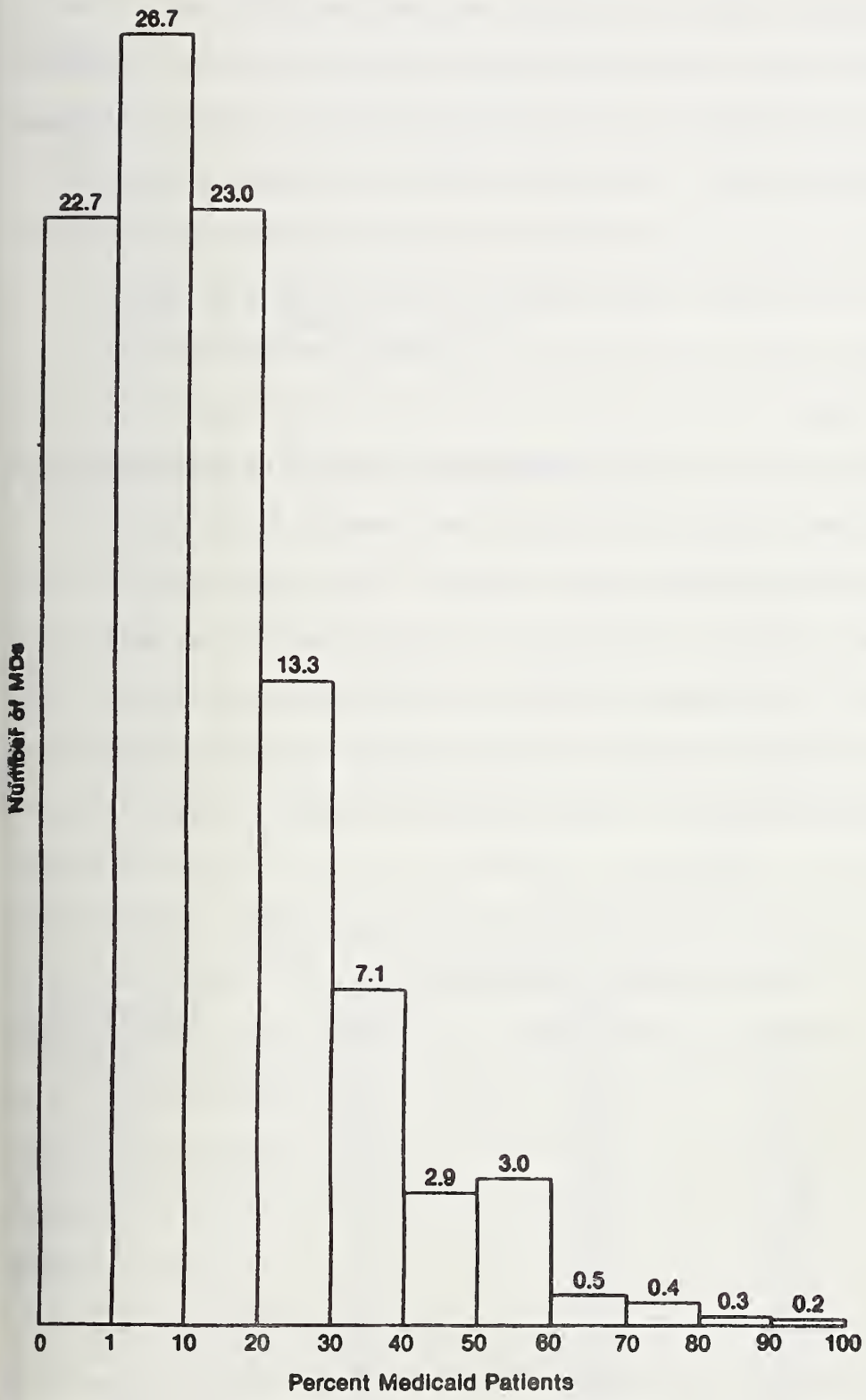
STUDY	DATA SOURCE	YEAR	PARTICIPATION MEASURE	OBSERVED LEVEL
			Proportion of Physicians accepting new Medicaid Patients (California, General/ Family Practice)	43.2%
			(California, Internal Medicine)	39.5%
			(California, Pediatrics)	61.2%
Henderson, 1977 (62)	National probability sample, survey	1975	Proportion of Medicaid eligible patients in the practice (Total)	16.7%
			(Pediatrics)	12.2%
"Is Anybody Happy with Medicaid"? 1978 (53)	readership survey	1978	Proportion of respondents seeing Medicaid patients	80.5%
Jones, 1977 (72)				
California	California Medical Association Members Survey	1974	Proportion of respondents seeing Medicaid patients	93.7%
		1977	Proportion of respondents seeing Medicaid patients	93.7%
		1974	Average proportion of patient load under Medicaid	9.7%
		1977	Average proportion of patient load under Medicaid	10.7%

STUDY	DATA SOURCE	YEAR	PARTICIPATION MEASURE	OBSERVED LEVEL
		1974	Average proportion of pediatrician's patient load under Medicaid	13.7%
		1977	Average proportion of pediatrician's load under Medicaid	13.7%
Kushman, 1977 (84)	claims data California	1973-74	Proportion of physicians in a region filing Medicaid claims during a year*	range - 56% to 100%
Sloan, Cromwell, & Mitchell, 1977 (121)	national probability sample, survey	1975	Proportion of physicians receiving Medicaid payments	70.8%
			Proportion of a reference week's total visits rendered to Medicaid patients (all physicians)*	10.3%
			Proportion of a reference week's total visits rendered to Medicaid patients (pediatricians)	10.8%

NOTE: An asterisk(*) indicates measures of participation which are used as dependent variables in multivariate analyses of physician participation in Medicaid.

SOURCE: U.S. Department of Health, Education and Welfare, Health Care Financing Administration. Variations by State in Physician Participation in Medicaid: Final Report. By S. M. Davidson and J. D. Perloff. In preparation.

FIGURE 1
Medicaid Participation Rate for All Physicians



This survey also documents varying levels of participation by physician speciality. With the notable exception of obstetrician-gynecologists, primary care practitioners are more likely to have large Medicaid practices than are specialists.(Table 2) (98). The authors suggest that this may in part reflect the role of primary care physicians as the "gatekeepers" of the health care system. In addition, usual fees for primary care practitioners may be closer to the Medicaid allowed fee than those of specialists, encouraging them to see a large number of Medicaid patients. Since medical and surgical specialists have undergone additional years of training and command higher fees for their services, human capital theory would hypothesize that <u>all</u> specialists, regardless of speciality type, would find Medicaid fees less attractive and hence be less likely to participate. As Mitchell and Cromwell point out, however, the two groups of specialists differ markedly in their mean level of Medicaid participation. Medical specialists are twice as likely as their surgical colleagues <u>not</u> to participate in Medicaid (Table 2), and likewise have far fewer LMPs. Surgical specialists on the other hand, more closely resemble primary care practitioners in their average willingness to treat Medicaid patients.

TABLE 2 (98)

Size Distribution of Medicaid Practices by Specialty

	Medicaid Practice Size			
Specialty	None	Small (under 30%)	Large (over 30%)	Average Medicaid Participation Rate
Primary Care	21.6%	62.6%	15.8%	13.3%
General Practice	24.3	60.8	14.9	13.5
General Surgery	8.4	75.1	16.5	14.3
Internal Medicine	18.1	62.5	19.4	14.5
Obstetrics/Gynecology	36.8	53.3	9.9	8.3
Pediatrics	24.1	58.5	17.4	14.3
Medical Specialties	32.2	58.8	9.1	9.0
Allergy	40.0	55.3	4.7	6.1
Cardiology	39.2	55.7	5.1	6.7
Dermatology	26.1	56.5	17.4	13.1
Gastroenterology	15.2	77.9	6.9	10.0
Surgical Specialties	15.3	71.7	13.6	13.3
Neurosurgery	18.3	71.6	10.1	10.9
Ophthalmology	12.4	72.7	14.9	14.4
Orthopedic Surgery	19.8	71.2	9.0	10.7
Otolaryngology	13.2	66.5	20.3	16.2
Urology	14.1	69.2	16.6	14.3
Psychiatry	39.9	51.7	8.4	8.0
ALL	22.6	62.9	14.5	12.7

BARRIERS TO PARTICIPATION IN MEDICAID AND EPSDT

A strategy to increase the participation of primary care physicians in Medicaid and EPSDT must address the factors that currently discourage them from treating program eligibles. While these factors differ somewhat from state to state, given the great variation in Medicaid and EPSDT programs, numerous common barriers have been identified. These can be grouped together in the following broad categories:

- Financial disincentives and professional costs
- Loss of professional autonomy
- Anti-Medicaid sentiment

Financial Disincentives and Professional Costs

A number of recent studies of physician participation in Medicaid have been grounded on the economic theory of price discrimination, defined as the sale of the same commodity at two or more prices. (127) Economists have observed that price discrimination is institutionalized in the market for medical care: the various sources paying for medical care -- individuals, private insurance plans, and public programs - consistently pay physicians different amounts for the same commodity. According to the theory of price discrimination, under such conditions the physician, like any other seller in the marketplace, will select as many patients as possible from the market that pays the highest price before selecting patients from the market that pays the next highest price. Because the level of reimbursement paid by Medicaid is frequently the lowest available to a physician, the Medicaid patient will usually be, from an economic standpoint, the least desirable patient.

This argument finds some support in the fact that one of the most extensively documented complaints about Medicaid and EPSDT, as compared with other payors, is the low level of reimbursement. (4, 37, 38, 41, 54, 58, 72, 73, 146, 155)

Not only have fees been set too low; they have also failed to increase over time, to reflect increasing costs and rising inflation. A 1979 study sponsored by the Massachusetts Medical Society noted that fees under Medicaid had remained at 1971 levels, despite the dramatic increase in the Consumer Price Index. While other payors had responded to price increases by raising reimbursement levels, Medicaid had adhered to its 1971 fee structure. The study concluded that low reimbursement levels played a major role is discouraging physician participation in the program. (8) The Michigan State Medical Society surveyed a sample of its membership for their opinions on problems with the Medicaid program in that state. Members were dissatisfied primarily with delays in and levels of reimbursement. (94) Other recent multivariate analyses have also shown that Medicaid participation is directly related to the level of Medicaid payment. (38, 60, 61, 84, 123, 146)

The problem of reimbursement is further complicated by the fact that reimbursement is frequently delayed or even denied altogether. (4, 37, 73, 121, 123, 155) The regulations governing eligibility for Medicaid are complicated. Any categorical program that bases eligibility on income will inevitably be plagued with problems of fluctuating eligibility among its client population. Clients eligible on one visit may be ineligible on the next. Claims for clients who are ineligible are denied and the physician's professional costs are not reimbursed. Fluctuating eligibility in general disrupts the relationship between the patient and physician and makes it highly unlikely that screening diagnosis and treatment will continue to age 21, an important objective of EPSDT.

Reimbursement can also be delayed or denied because of problems with physicians' invoices. Utilization controls and changes in the scope and duration of services covered by the state Medicaid program frequently cause invoices to be rejected. Such problems also raise providers' collection costs and discourage participation. (37, 146)

Loss of Professional Autonomy

Many physicians are reluctant to participate in Medicaid and EPSDT because they dislike "bureaucratic interference with patient care." (73) Because Medicaid may cover only a limited range of services, physicians feel hampered in their ability to exercise full discretion in treating a patient: treatment is determined to some extent by regulations governing which services are covered and which are not.

The problem of physician autonomy is magnified several times in the screening component of EPSDT, as compared to Medicaid generally. Unlike the parent Medicaid program, EPSDT requires states to define screening packages (a set of tests and procedures which constitute the screening examination for particular age groups) and periodicity schedules (recommended frequency of screening examinations). Although the guidelines require that states work with physician groups to develop the screening package and periodicity schedule, not all physicians agree as to which services are necessary at a given age. (147) Conversely, they may believe that certain services should be provided, but are not covered, or that the allowed frequency of screenings is incorrect. EPSDT is also distinguished from Medicaid in the extent to which states establish standards for components of the screening package. Because of the nature of screening tests and the limited number of such procedures, some states define specific procedures that must be performed and criteria that would distinguish normal from abnormal results. In Ventura County, California, for example, many physicians did not want to become EPSDT providers because they did not have the audiometric equipment required for the hearing test. (27) In fact, because of strict definitions and limitations on assessment services and

frequency, physicians feel - and resent - that they are being told how to practice medicine.

Physicians also complain about the amount of paperwork that stands between them and the patient. (4, 37, 38, 54, 121, 123, 146, 155) EPSDT requires states to assure that all children are diagnosed and treated for each condition that is found to be abnormal in the assessment. To meet this demand, states must follow children's progress through the medical and dental services and intervene to assist families if needed services are not being received. Thus, providers are generally required to complete a more detailed claim form for EPSDT services than they typically complete for Medicaid or private insurance.

Complex reporting requirements and claims forms place added burdens on physicians and their clerical staff, increasing professional costs and causing confusion. Forms must sometimes be resubmitted because of clerical misunderstanding, thereby adding to delays in processing. Hopkins, in a survey of physician attitudes toward California's Medicaid program, identified strong provider dissatisfaction with the burdensome paperwork of claims processing. (66) Jones and Hamburger similarly found that one of the most significant criticisms of Medi-Cal, in addition to inadequate levels of reimbursement and retrospective denial of reimbursements, was the excessive amount of paperwork. (73)

Another aspect of "professional autonomy" is also threatened through certain quality assurance and utilization control procedures established by states to control Medicaid costs. Physicians particularly resent the necessity of obtaining "prior authorization" before rendering certain services. This requirement often results in the postponement of treatment with a loss of time for client and physician alike. Gluck and Jong, in a survey of dentists participating in Medicaid in Massachusetts, found

considerable dissatisfaction with the requirement for prior authorization, which is sometimes carried to extremes. For example, dentists who have received authorization to fill two sides of a tooth cannot technically fill a third without formally applying for further authorization. (56, 57)

Providers in general complain that there is insufficient communication between them and state administrators of Medicaid and EPSDT. They resent being told how to practice medicine by non-physicians. When problems are not resolved quickly enough, frustration among providers grows as does the unwillingness to participate in the program.

Anti-Medicaid Sentiment

Anti-Medicaid sentiment is a particularly important consideration because of the pervasiveness of class discrimination and racial prejudice in our society. The Medicaid population is generally poor, less formally educated and largely made up of single-parent, minority families. Socio-economic factors and prejudices, although not easily studied and documented, are an extremely important influence on physician participation in programs like Medicaid and EPSDT.

> "Physician know thyself" is not an idle aphorism, for inevitably, the physician must draw upon his own life experience to develop understanding and empathy for his patients. But physicians do not share the life experience of low-income patients; they cannot use their past experience to understand these patients. This social distance can be an impediment to communication and to relations . . . " (28)

It is not coincidental that in 1970, the fifteen counties with the highest per capita incomes had seven times as many practicing doctors per capita as did the fifteen counties with lower per capita income. (40)

One barrier to physician participation in Medicaid and EPSDT is a general dislike of the Medicaid client population. A 1977 report by the American Academy of Pediatrics gave the following reasons for the unwillingness of

providers to treat Medicaid patients:

- extra time and effort required to care for seemingly unappreciative patients;
- irresponsible recipients who disrupt schedules by frequently missing appointments; and
- difficulty in understanding and communicating with eligibles due to language differences. (147)

Another study conducted by Brian and Gibbens in California found that providers complained frequently that Medicaid recipients "over-utilized" physician services for the treatment of minor, non-emergency conditions. Providers were reluctant to expand their case loads with more Medicaid recipients, because they did not want to increase the number of time-consuming, low-revenue producing procedures demanded of them. (17)

BARRIERS TO PROVIDER PARTICIPATION IN EPSDT

Several researchers have studied barriers to provider participation in EPSDT specifically. These studies highlight problems that are unique to EPSDT, many of which are related to the state-established screening, periodicity schedule, referral criteria and quality assurance standards. In 1975 the American Academy of Pediatrics (AAP) surveyed state EPSDT administrators and AAP chapter presidents in fifty states. (4) The survey covered areas that the private providers viewed as barriers to participation. It also assessed the degree of communication between private providers and state EPSDT administrators. The major barriers to participation identified by the providers were, in order of priority:

- insufficient communication with state administrators
- lack of physician familiarity with EPSDT
- inadequate and delayed claims payment

- lack of encouragement by states to physicians to participate in EPSDT, and,
- inappropriate or complex claims payment forms.

The order of priority is significant. Previous studies of Medicaid and EPSDT found that forms and fees were the major deterrents. This study identifies insufficient communication with state administrators as the foremost deterrent while forms and fees have fallen into the background. The respondents frequently indicated that as long as sufficient communication existed with state administrators, low levels of reimbursement would not prevent private providers from participating.

In 1979, Health Information Designs, Inc. (HID), a HCFA contractor, conducted a comprehensive study to identify issues having potential influence on the implementation and operation of the proposed Child Health Assurance program (CHAP). (139) In their study, HID staff surveyed and interviewed provider organizations and state EPSDT staff to identify barriers and incentives to provider participation in EPSDT. The HID staff contacted representatives of the American Academy of Pediatrics (AAP), American Medical Association (AMA) and the American Academy of Family Practice (AAPP). The AAP reconfirmed the findings of its 1975 report, identifying its major concerns as:

- lack of communication between physician and state EPSDT staff
- untimely payment of claims, and
- low reimbursement levels.

The AMA identified its major concerns as:

- slow and inadequate reimbursement
- inadequate outreach and follow-up efforts by EPSDT staff, and
- undemonstrated success of EPSDT, based on the AMA's EPSDT demonstration project in Illinois.

The AAFP identified its major concerns as:

- too much paperwork
- excessive state and federal controls
- low reimbursement
- lack of provider input in EPSDT program planning, and
- duplication of services. (139)

The HID staff also surveyed EPSDT program staff in six states: Arkansas, Illinois, North Dakota, North Carolina, Oregon and Tennessee. In summary, EPSDT state program staff felt that provider unwillingness to participate was attributed most often to unsatisfactory reimbursement rates. Other disincentives to program participation included excessive paperwork, untimely reimbursement, no-show attribute of recipients, large case loads, and a general anti-Medicaid sentiment. (139)

The 1976 Children's Defense Fund study of EPSDT identifies the following significant barriers: (29)

- inadequate and delayed reimbursement
- excess paperwork and,
- general lack of communication between providers and state program staff

Applied Management Sciences (AMS) developed a Barrier Assessment Report identifying factors that inhibit the successful implementation of EPSDT at the state level. (9) AMS staff surveyed state EPSDT staff to identify specific barriers to private provider participation. Those barriers included:

- physician doubt concerning the usefulness of preventive medicine as exemplified by the EPSDT screening package
- physician disinterest in the Medicaid program in general, because of the paperwork required, the uncertainty of reimbursement or the rate of reimbursement
- a high percentage of "no shows" for appointments

- a lack of financial incentives to participate. The fee for screening services and for additional treatment services (especially certain dental procedures) was established within the bounds of the existing Medicaid rate-setting system. (9)

Forward Management Associates for a HCFA contract conducted an evaluation of the EPSDT program in Pennsylvania. (138) Their study indicates that barriers to participation in Pennsylvania include:

- low level of reimbursement
- delays in reimbursement
- excess paperwork and
- general aversion to socialized medicine

INCENTIVES TO PROVIDER PARTICIPATION IN EPSDT

Any successful provider recruitment plan must begin by understanding both positive and negative features of the program from a provider's viewpoint. Although it is important to examine what deters physicians from participating, it is likewise important to examine what motivates them to participate in the EPSDT program. Specific marketing techniques can then be developed in response to providers' likes and dislikes.

Some factors found to motivate physician participation in the EPSDT program include:

1. Altruism - by providing health care to poor children, a physician's altruistic sense is satisfied.
2. Disease Prevention - since the program requires screening and early detection of disease, it is deemed worthwhile from a preventive medical standpoint.
3. Competition - primary care physicians in some cities are increasingly

competing for the same patients and may welcome an opportunity to see additional patients whose regular care is reimbursable.

4. The Fixed Rate of Reimbursement - some states have established a fixed fee reimbursement schedule for EPSDT separate from their usual and customary fee schedule for Medicaid. Although providers frequently object to a fixed schedule, many prefer it because they know exactly how much they will be reimbursed. (137)

Many of the barriers to physician participation in EPSDT described above, i.e., low reimbursement, delays in reimbursement and excessive paperwork, represent problems that have plagued most state EPSDT and Medicaid programs since their inception. Elimination of these barriers would require some modification of the EPSDT programs themselves. Short of actual program modifications, however, there are some suggested and proven methods to improve physician satisfaction with the program. Those problems that are intrinsic to the program "process" (communication, participation in planning, and policy making) can be dealt with effectively by an intensive marketing effort.

A 1978 evaluation of California's CHDP program singled out the following incentives to increase physician participation in EPSDT: (131)

1. Competitive fee structure: In California, the revised CHDP structure offers an acceptable return to providers of screening services. Since its revision, it pays more for services than the Medi-Cal reimbursement. Considerable evidence has been accumulated to support the contention that increasing the level of reimbursement would be an effective policy instrument for increasing the participation of physicians in Medicaid and EPSDT.

2. Prompt payment of claims - Claims payment has been cut in some states to 30-45 days for EPSDT compared with 3-5 months for regular Medicaid claims.
3. Reduction of costs related to claims processing - Literature suggests that efforts to minimize the physicians' billing and collection costs might be effective in promoting greater participation in Medicaid and EPSDT. This might be done through a streamlined computerized claims processing system.
4. Elimination of prior authorization - Limiting the requirements for prior authorization for some EPSDT related services is suggested as a method to help foster greater participation in EPSDT.
5. Improvement in communication - In response to the complaint that program decisions are often made without physician consultation, state and/or federal networks to insure regular communication between program administrators and providers can be instituted. The state Medicaid Advisory Committee is one forum in which such dialogues may occur. In addition, the timely communication to providers of changes in Medicaid regulations and procedures might greatly facilitate provider participation and retention.
6. The periodicity schedule - In most states, the periodicity schedule offers the opportunity to provide services more frequently to infants than the annual well-child billing under Medicaid. This serves to attract some physicians into the program. (131)

In a 1980 assessment of the availability of physican services to Medicaid beneficiaries, conducted by the Office of Service Delivery Assessment of Region VI, physicians indicated that the following incentives would improve

provider participation:

> All physicians interviewed agreed that higher reimbursement rates would be the number one factor in encouraging them to expand their Medicaid practice. Number two in importance was rectifying the indeterminate Medicaid eligibility of clients, which relates to the continuous redetermination of status by state agency. The third priority relates to the implementation of a simplified and more effective coding system for the payment of claims. Fourth priority was given to the question of broader service coverage. Physicians found it frustrating to have to limit care to the number of visits or prescriptions allowed by the state program. They label this as intervening in provision of health care. The last item of priority was reduced turnaround time in the payment of claims. This relates primarily to the number of claims returned for additional information or justification. (42)

In a 1979 survey of pediatricians, the American Academy of Pediatrics tested the relationship between levels of participation in the Medicaid program and program characteristics. The purpose of the survey was, in part, to identify ways in which policy makers and administrators could stimulate participation through alterations in policy. Preliminary results of the survey indicate that levels of participation are indeed responsive to a number of program characteristics including, in descending order of importance:

- The ratio of a state's income eligibility level for AFDC to the poverty line: that is, the higher the level in relation to the poverty line, the greater the participation.
- The number of optional services covered by the state's Medicaid program.
- The state's average fee for a well-child visit.
- Length of time it takes to be reimbursed by Medicaid.

Based on these findings, the authors recommend that the following program-related incentives be given consideration by policy makers and administrators:

- Raising AFDC eligibility levels, thereby making the eligible population more stable.
- Increasing the number of optional services, thereby removing arbitrary barriers to the physician's exercise of his professional judgement in treating patients.
- Ensuring prompt payment of bills.
- Raising the fees (at least in comparison to other payors), so that participating physicians will be willing to treat larger numbers of Medicaid patients. (1, 2, 39)

SECTION III

PROVIDER PARTICIPATION IN OTHER PUBLIC HEALTH PROGRAMS

In addition to EPSDT and Medicaid, there are a number of other government programs which have experience in recruiting private providers. Several of these programs (Blue Shield, Medicare) are health care financing programs similar to Medicaid and EPSDT. Other programs (National Health Service Corps, Indian Health Service) employ physicians for the delivery of medical care. Programs like Head Start must recruit physicians often at lower than market prices to provide a specific set of health services to enrollees. The experience of all three types of programs in provider recruitment are relevant to the study of EPSDT provider recruitment. Factors which influence provider participation in these programs may apply similarly to EPSDT.

NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps program was created to help remedy the uneven geographic distribution of health manpower by hiring and placing physicians in shortage areas. According to a 1978 report by the Comptroller General, Progress and Problems in Improving the Availability of Primary Care Providers in Underserved Areas, the Corps has achieved only moderate success. While it has increased the availability of physicians in many shortage areas, it has been unable to recruit them to serve in more remote, less populated areas, many of which have remained unstaffed for four years. Its incentive structure, which includes a policy of placing a minimum of two physicians at any site and a scholarship program with a shortage area service obligation, has not proved sufficiently attractive. The Corps has largely failed to

achieve its objective of persuading physicians to establish private practices in shortage areas following their period of service. During the first years of its operation, only 5% of NHSC physicians chose to do so. Principal factors affecting location decisions, as identified by this report, include the availability of clinical support, contact with other physicians, and continuing education opportunities. Economic factors such as income potential and availability of loans were less important. The NHSC recognizes the need to design programs to meet these needs, if it wishes to improve its success with recruitment and retention of physicians. (117, 153)

The NHSC also has had problems retaining its scholarship recruits in the program after they complete their medical training. Approximately 30 percent of all NHSC scholarship program graduates arriving at their time of service have defaulted on their obligation to serve and have opted instead to repay the Government for the scholarship money they received. According to Fitzhugh Mullan of the National Health Service Corps, one explanation for this high rate of default is to be found in the lack of activities designed to reinforce the scholarship recipient's initial decision to serve in the Corps. By the time many recipients finish their medical education, their interest in providing health care to the underserved has given way to the attractions of the private practice model. Mullan attributes this loss of committment to the curriculum of most medical schools, which offers few programs to help prepare young physicians for careers in the field of public health. While the Corps would like the schools to assume this responsibility in the long run, it also recognizes the immediate need for activities to retain medical students in the program after their initial recruitment. To this end the Corps has organized a preceptorship program for students at NHSC sites; "acclimation conferences" at which teams of

NHSC administrators and NHSC physicians discuss current issues relating to the Corps with scholarship recipients; and Corps-related publications, for instance a series of indepth profiles of current NHSC assignees and the clinics in which they operate, to be circulated to recipients. (100)

The experiences of the NHSC program have several implications for EPSDT provider recruitment efforts. The decision to join the Corps, particularly among scholarship recipients, is based on both financial and altruistic considerations. Undoubtedly, many physicians join the program in medical school because they have insufficient personal finances to pay for their medical school expenses. Other physicians, however, are attracted to the Corps for an altruistic reason; namely, a desire to provide care to residents of poor underserved areas. These physicians have personally overcome one of the barriers to participate in EPSDT; namely, a reluctance to serve low-income patients. As such, these physicians should be desirable candidates for recruitment in EPSDT.

The decision to locate and settle in underserved areas is based on several factors as noted above. Of particular note is the need for continuing professional education and contact with other physicians. EPSDT program staff can attempt to address these needs by holding special workshops for rural providers and staff, cooperating with statewide professional organizations in the presentation of continuing education workshops on pediatrics and preventive care and developing provider information bulletins which address medical and health-related issues as well as administrative issues.

INDIAN HEALTH SERVICE

The Indian Health Service (IHS), United States Department of Interior, employs physicians in IHS health care facilities throughout the United States. IHS physicians include commissioned and volunteer members of the National Health Service Corps. Corps physicians serve in the IHS for a minimum of two years. Most physicians join the Indian Health Service after completion of their internship and residencies. (153)

Conversations with IHS recruitment staff indicate that the most successful IHS recruitment methods include advertisements in medical journals, such as the New England Journal of Medicine, mass mailings to medical school graduates and personal referral of colleagues by current IHS physicians. Because of the similarities between IHS and EPSDT provider recruitment, these recruitment methods may be helpful in developing a marketing strategy.

BLUE SHIELD AND MEDICARE

The Blue Shield "service benefits" plan reimburses for services to insured members. There is no out-of-pocket payment for services by the member to the physician. Instead, the participating physician agrees to accept a fixed reimbursement amount from Blue Shield as payment-in-full for services delivered to plan members. As Sloan and Steinwald note, the plan has several features in common with Medicaid. These features include a primary focus on the low-income population, a limitation on payment to a maximum reimbursable amount, and voluntary participation by physicians. (124)

Major factors which influence physician participation in Blue Shield "service benefit" plans include the level of reimbursement, absolutely and in comparison to the reimbursement schedules of other third-party payors; case-by-case participation, rather than mandatory participation by all patients

in a practice who are covered by Blue Shield; and the value of "in-kind" benefits associated with the plan - direct billing to the insurance company, rather than to the patient; and the reduction of bad debt. (124)

The Blue Shield "service benefit" plans are analogous to Medicare assignment. Under Medicare assignment, physicians agree to accept reimbursement from the Medicare program as payment in full for all services delivered to Medicare beneficiaries. Beneficiaries are, of course, still liable for the standard Medicare deductible and co-insurance. However, besides these amounts, physicians cannot bill patients directly for services. Several authors, including Paringer, have analyzed physician participation in Medicare assignment. In summary, the authors find that physician willingness to accept assignment is predicated on the level of reimbursement and the advantages of third party versus direct patient billing (more timely payment, lower bad debt). (109)

The Blue Shield "service benefit" plan and the Medicare assignment plan have several implications for EPSDT. Most significantly, the plans suggest that prompt claims payments and competitive levels of reimbursement encourage physician participation. In addition, because of similar clientele (low income patients) physicians who participate in Medicare assignment and Blue Shield "service benefit" plan may be key targets for recruitment for EPSDT.

Lastly, because of similarities in the programs, there may be benefit to marketing all programs - Medicare assignment, "service benefit" and EPSDT - as a package , rather than separately. Cooperation between EPSDT, Medicare intermediaries and Blue Shield would be required for this joint marketing effort.

HEAD START

The federally funded Head Start program, in operation since 1965, serves children 3 to 6 years of age, 90% of whom must be from families at or below the poverty level. The provision of preventive and ameliorative health services comprises one major component of Head Start. In fact, the requirements for Head Start screening exams closely parallel the recommended EPSDT screening schedule and the requirements for follow-up diagnosis and treatment are similar for the two programs. Each local Head Start program must solicit the cooperation of local health care providers, both public and private, to arrange the delivery of medical and dental care services for its enrollees. Publications such as the Head Start Health Advisory Committee Handbook (86) and Project Head Start Health Services (106) provide guidelines to staff of individual Head Start programs for recruiting health services providers from their own communities.

The most common approach suggested for Head Start provider recruitment is for staff to meet with physicians and other potential providers at the Head Start facility while the children are present. Often, they arrange lunch with the students. When the physician observes and talks with these children, he or she will perceive them as real people with real needs and not just part of another government program. Then the physician is more likely to adjust his/her schedule or fees to meet the needs of the community's Head Start program. This approach has also been utilized successfully for arranging EPSDT services for eligible Head Start enrollees as described in Head Start and EPSDT: Recipes for Success. (151) A companion piece, Head Start and EPSDT: A How-To Guide for Head Start Programs gives step-by-step instructions for obtaining the support of EPSDT providers to meet the needs of Head Start programs. (152)

SECTION IV

PROVIDER RECRUITMENT ACTIVITIES - EPSDT

In 1974, the American Medical Association, under contract with DHEW, prepared a Report on Professional Health Provider Participation: EPSDT/ Medicaid, which formulated broad guidelines for the role of national, state and local organizations in the provider recruitment effort. The report recommends that DHEW "should establish an on-going program geared to elicit the continual support of national health and welfare organizations;" that "all state and local EPSDT administrators should seek the full cooperation and participation of health care providers through their appropriate professional societies and specialty organizations;" and that "state and local professional organizations should inform and encourage their members to participate in this program." Within these broad guidelines, agencies and organizations were to devise their own specific recruitment techniques. (144)

FEDERAL

Since EPSDT is a state-administered program, the federal role in provider recruitment has been limited, a fact deplored by the Children's Defense Fund. (29) When the EPSDT program was enacted, its authors assumed that adequate providers were available and would automatically become participants. (133) When this did not prove to be the case, DHEW began funding research and demonstration projects aimed at remedying this and other implementation problems. Numerous guides have been produced to serve as educational and recruitment tools for state and local agencies. In addition to the report by the Committee on Health Care of the Poor, DHEW contracted with the American Academy of Pediatrics to prepare a Guide to Screening -- EPSDT Medicaid, (150) a Guide to Administration, Diagnosis and Treatment: EPSDT, (147) and a Final Report: Increased

Professional Provider Participation in State and Local EPSDT Programs. (4) In 1977, HCFA sponsored a national conference on "Medicaid and the Health Care Provider: A Partnership" and published a lengthy Conference Report. (140) Other efforts at the federal level include preparation and dissemination of promotional brochures aimed at providers, such as "EPSDT Needs Physicians and Dentists" (132) and a more substantial eight part pamphlet series EPSDT Information Booklets and Training Materials. (141) The Bureau pf Labor Statistics and other branches of government provide on-going compilation and analysis of health manpower statistics resulting in such reports as Progress and Problems in Improving Availability of Primary Care Providers in Underserved Areas (153), and Critical Health Manpower Shortage Areas: Their Impact on Rural Health Planning, put out by the Department of Agriculture. (48) Such studies shed useful light on patterns of physician distribution and factors that influence location decisions. Key findings will be summarized in a later section.

STATE AND LOCAL

The major burden of provider recruitment falls to the state and local EPSDT programs. EPSDT regulations mandate that every state develop agreements with health care facilities and practitioners to provider EPSDT services. Accordingly, each state has in effect become unofficial "demonstration project" for recruitment strategies. (133) States have had varying degrees of success with provider recruitment. In some states, like Pennsylvania and California, there are effective provider recruitment strategies and high levels of private provider commitment to the EPSDT program. In other states, like Indiana, Nevada and Mississippi, EPSDT programs have been relatively less successful in recruiting private providers. (4)

In a 1977 study, the Children's Defence Fund (CDF) found that most state agencies limited their recruitment to sending letters to Medicaid

providers briefly explaining EPSDT and inviting participation. Little attempt was made to identify and to recruit physicians who were not providing services under Medicaid. The CDF condemned most of these state activities as "haphazard and ineffective." (29) The American Academy of Pediatrics (AAP) in its report on Increased Professional Provider Participation came up with similar findings: among 42 states surveyed, 24 (57%) reported negative or mixed provider attitudes toward EPSDT. (4) And there was a high correlation between states reporting negative attitudes and low provider participation in the EPSDT program. The AAP concluded that the foremost deterrent to participation by private providers in EPSDT was insufficient dialogue with state administrators. (4)

Effective communication between providers and state officials has emerged as the single most important factor in recruiting and retaining providers. States that have evolved successful programs are increasingly being held up as "models." According to Miller, Pennsylvania state officials, recognizing that they could not assume the automatic participation of medical providers, hired two contractors to develop a well-planned "sales campaign" aimed at physicians and dentists. Given the complexity of the new program, planners decided that mass mailings would be ineffective and opted instead for personal contact. "Recruiters" drawn from the ranks of nurses and drug salesmen, were trained to make "sales calls" on providers and their office staff to explain the program and its implementation. Technical assistance was made available to acquaint staff with billing procedures. Recruiters made return visits periodically to discuss problems and act as liaisons between providers and the state. (97)

Castillon, Leonard and Liberatore, in a 1978 provider resources study of California's CHDP program, also identified "personal contact" as the most successful recruitment technique. In California, where provider recruitment

is largely the responsibility of local programs, public health nurses have, through trial-and-error, developed strategies similar to those used in Pennsylvania. (25) In the San Gabriel Valley, where recruitment has been most successful, the public health nurse identifies potential providers by consulting a health educator, the advisory council, school nurses, parents and Head Start directors, participating physicians and even the telephone directory. While the health educator undertakes a general marketing effort to explain the program to the community at large, the public health nurse makes personal calls on potential providers. A variety of activities are used during the recruitment process. While meetings with providers and staff are the most common, other activites include mass mailings, telephone contact, newsletters, slide/tape presentations, articles in professional publications, development of a "provider notebook," advisory board activity, workshops and staff training. Local CHDP staff may also offer support services including correcting bills, providing client reminder post cards, helping set up tickler files and visiting providers when changes are made in the program or billing forms. (131)

Specific Studies by State

Numerous other studies identify effective state strategies for achieving good communication with EPSDT providers. Michigan's Bureau of Medical Services places great importance on provider education and provider involvement in program planning. These responsibilities are assigned to the Bureau's Medicaid Information Division. Comprehensive provider manuals, specific to provider type, are sent to all providers that enroll in the Medicaid program. The manuals are reinforced by seminars conducted throughout the state and by periodic newsletters highlighting recent developments. Toll-free telephone

"hot lines" are used to respond to provider's questions and field representatives are available for on-site visits. The Medicaid Information Division holds monthly MMIS working seminars to improve clerical capacity to handle the required paperwork. To involve providers in the planning process, the Bureau holds formal quarterly meetings with each provider association in the state to exchange ideas and discuss questions of policy. (16)

The Iowa Medicaid program communicates with private providers through professional advisory committees and the Medicaid Assistance Advisory Council. The program solicits the advice and consent of provider groups on changes in Medicaid program planning and policy. The professional advisory committees represent the special interests of various health care professions (medicine, dentistry, pharmacy, etc.). The Advisory Council is comprised of representatives of different health care professions. The Council functions as a unique policy advisory group to the state program.

In addition to these groups, Iowa's Medicaid fiscal intermediary is also active in provider relations. The intermediary has a Provider Relations Department which provides on-site consultation and guidance to providers on the scope of Medicaid services, client eligibility and claims processing and claims payment. (140, pp. 212-23)

Studies of Virginia and Texas reveal similar provider recruitment strategies. As in Iowa, each state has a Medical Care Advisory Committee composed of representatives of all provider groups in the state. The Committee meets periodically to make recommendations on changes in program planning and policy. In Texas, high-level state staff maintain close formal and informal communication with executive staff of professional societies. This communication ensures that provider problems are identified and resolved quickly and that state-initiated program changes can be implemented with the knowledge and support of the provider community. (58, 95, 149)

A 1976 study of EPSDT provider recruitment activities in six eastern states suggests that mail and personal contact with private providers has met with limited success:

> "Contacts with the private sector consisted primarily of letters and medical assistance bulletins sent to individual physicians and to local medical associations. Personal contact with these individuals and/or groups was also used in some cases. Results of these efforts proved to be a disappointment to EPSDT state managers." (136)

The study indicates that a more effective approach would incorporate provider recruitment into an overall strategy to improve the EPSDT "product". This strategy could include the development of financial incentives to participation, reduction of the paperwork required for claims processing and prompt reimbursement.

Pennsylvania has promoted provider participation in EPSDT in several ways. On a contract basis, program field representatives make visits to providers' offices and conduct a two-hour training session to orient them to the EPSDT program. In each training session, the provider receives a copy of the program manual and verbal instructions on claim forms, processing and payment. Field representatives revisit providers within five or six weeks after the initial agreement to provide follow-up instruction and if needed, to train new employees in EPSDT procedures. Significantly, field representatives include administrative as well as health care professionals with backgrounds in medical sales and nursing. Their professional experience is invaluable in selling the EPSDT program to providers and in ensuring that the program itself is sensitive to the everyday needs of private practioners. In addition to site visits, the EPSDT program encourages provider participation through mail solicitation of non-participating providers and meetings with medical societies and health related professional organizations. (138)

The American Academy of Pediatrics (AAP) study of increased professional provider participation included a mail survey of the EPSDT chairpersons of AAP chapters in ten regions. The chairpersons were surveyed for information on provider recruitment activities and barriers to provider participation in their region. The survey documents the following recruitment activities:

New York - Physicians are informed by announcements in the State Medical Journal, State Medical Society Newsletter, and AAP Newsletters. A pediatrician has been designated by the AAP to promote EPSDT and work as a liaison with the state EPSDT program.

New Jersey - Providers are informed about EPSDT through notices in professional journals and newsletters and in a special newsletter distributed periodically by the state Medical Assistance (Medicaid) program. Medical Assistance program staff also have personally contacted providers to explain the EPSDT program to them and to solicit their participation in the program. There is also a Child Health Care Advisory Committee comprised of representatives of various health care professional organizations. The Committee enchances communication between the state EPSDT program and private providers.

Illinois - Regional EPSDT (Medicheck) coordinators inform providers about program regulations and policies and assist them in problems with claims processing and payment.

Kansas - Kansas uses a statewide mailing to recruit and inform physicians about EPSDT. Nebraska distributes letters, pamphlets and bulletins. Iowa distributes a provider handbook explaining the program. (4)

Summary

In summary, authors have identified the following methods, used by state and local EPSDT programs to assure provider participation in EPSDT:

Publications

- EPSDT and Medicaid Provider Bulletins and Newsletters
- Articles on EPSDT in professional journals and publications
- EPSDT provider manuals

Organizations

- Child Health Advisory Board
- Committees of health care professionals (physicians, dentists, etc.)

Personal Contact

- training sessions with individual providers and their staffs
- training sessions with groups of providers and their staffs
- provider workshops and conferences
- attendance and presentations at meetings of state and local professional societies
- technical assistance to providers in completion of claim forms
- telephone "hot line"
- consultation with providers and provider groups in setting program policy

PRIVATE

Among professional associations, the American Academy of Pediatrics (AAP) has been the strongest advocate for the EPSDT program. As its 1976 report on Increased Professional Provider Participation in State and Local EPSDT Programs testifies, the national AAP has taken an active interest in physician recruitment primarily by campaigning for the elimination of disincentives to participation. (4) Following this report, it diminished its emphasis on EPSDT and broadened its focus to the entire Medicaid program. The AAP would like to see basic structural changes in Medicaid that would help solve the problems

of physician participation. To this end, it has sought to mobilize state chapters to intervene in the policy-making process of their state Medicaid bureaus. It prepares and distributes state-specific "Medicaid kits" which provide information on eligibility criteria, data on numbers of providers and recipients, and description of the administrative and fiscal organization of the state program. It has also recently begun to publish a newsletter, "Medicaid News" to keep pediatricians up-to-date on Medicaid regulations, policy changes and state developments. (5) In 1979 it undertook an ambitious "Survey of Pediatrician Participation in State Medicaid Programs," funded by a grant from HFCA, to establish relationships between state policy characteristics and physician participation. The AAP interviewed 814 office-based physicians in 13 states. The research sought to identify strategies for increasing participation and improving the effectiveness of state programs. While final results are as yet unpublished, preliminary findings indicate that state policy makers do have options that could be used to foster full participation among physicians in their states. Apart from raising physician reimbursement levels, they can expand optional services covered by the program, institute more liberal policies toward the states' medically needy and expedite reimbursement of physician's bills. (1, 2, 39)

SECTION V

PARTICIPATION BY DENTISTS IN EPSDT

According to A Guide to Screening: EPSDT--Medicaid, virtually all children over the age of three are in need of treatment for dental problems. (150) Yet, according to the most recent National Center for Health Statistics "Health Interview Survey" on utilization of dental services (1978), 30% of all American children under age 17 had never made even one dental visit. (135) Income level is the primary factor in the utilization of dental services. (173) The lower the income of a family, the less likely its members will be to seek dental care. A 1975 study indicated that 66% of all children from families with incomes less than $4,000 have never been to a dentist. (176) Similar findings are reported in the DHEW Dental Manpower Fact Book (March 1979) which analyzes utilization of dental services by demographic variables. Variations by color, family income, and education of head of family result in striking differences in utilization rates (Table 3). These data underscore the need for improving the delivery of dental care to the poor. (187)

The dental component of EPSDT was intended to improve access by bringing millions of indigent children and youth into the dental care delivery system. The inclusion of dental care as a mandated service under EPSDT has an interesting history. The evolution of federal regulations governing the EPSDT program was marked by vigorous debate. (51) Officials of the Medical Services Administration (MSA) supported by the National Legal Program on Health Problems of the Poor and Welfare rights groups, argued for comprehensive services exceeding

Table 3

PERCENT OF PERSONS WITH ONE OR MORE DENTAL VISITS WITHIN A YEAR AND AVERAGE NUMBER OF DENTAL VISITS PER PERSON PER YEAR, BY DEMOGRAPHIC CHARACTERISTICS: 1977

Demographic characteristics	Percent of persons with dental visits within a year	Average number of dental visits per person per year
All persons	49.7	1.6
Sex		
Male	48.3	1.5
Female	51.1	1.7
Age group		
Under 17 years	51.0	1.5
17-24 years	55.2	1.6
25-44 years	53.5	1.7
45-64 years	48.7	1.8
65 years and over	31.4	1.3
Color		
White	51.9	1.7
All other	35.4	1.0
Family income		
Less than $4,999	34.0	1.1
$ 5,000- 9,999	38.1	1.2
10,000-14,999	46.8	1.4
15,000 or more	61.9	2.0
Education of head of family		
Less than 9 years	30.2	1.0
9-11 years	39.8	1.4
12 years	51.9	1.6
13 years or more	64.1	2.1

SOURCE: U.S. Department of Health, Education, and Welfare, National Center for Health Statistics. Provisional data, unpublished.

the limits of states' existing Medicaid plans. State officials, on the other hand, objected to losing control over the scope of their programs and pleaded a lack of manpower and resources to carry out a comprehensive plan. MSA officials yielded, and the regulations that evanually emerged in 1971 asked states to provide EPSDT "within the limits of the state plan on the amount, duration and scope of care and services." The only mandated treatment services beyond the state plans included: ". . . eyeglasses, hearing aids, and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health." (39, 51, 134)

Under these regulations, however, referrals to a dentist for treatment still depended on the discretion of the person providing the screening, who might or might not be trained in making dental assessments. On October 1, 1979, new EPSDT regulations went into effect that greatly improved access by children to dental treatment under the program. The screening package now included "dental services furnished by direct referral to a dentist for diagnosis and treatment" for all children three years of age and over. Treatment was to include "Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health." (30, 134)

Despite the regulations guaranteeing a minimum standard of dental care for eligible children, there is evidence to suggest that implementation of this component of EPSDT has been less successful than implementation of the medical component.

Until October 1979, when the new EPSDT regulations became effective, the Children's Defense Fund noted that, according to national EPSDT statistics (1977), an average of only 25% of EPSDT screenings resulted in a dental referral, with considerable variation according to state. In a study of five test states, the CDF found the following rates of referral for dental problems:

State	Percent Referred
Michigan	31
Mississippi	61
New York	7
New Jersey	6
South Carolina	49

The authors concluded that "dental referrals are all too frequently omitted from the care children receive under EPSDT." Either the health personnel doing the screening were not sufficiently trained to notice any but the most serious dental problems, or they did not perform dental assessments as a routine part of the screening package. (29) EPSDT data for 1978 reveal similar low and varied levels of referral for dental conditions. (182)

According to a survey by the American Dental Association, conducted at the end of 1978, utilization of dental services by Medicaid-eligible children stood at unsatisfactory levels (Table 4). In the eleven states that offered dental benefits only under the EPSDT program, for example, the percentage of eligible children receiving at least one dental service in 1977 or 1978 ranged from only 15 percent to 66 percent, with an average of 35 percent. (157)

TABLE 4 (157)

STATE	% of Medicaid Eligible Children Who Received at Least One Dental Service.
Alabama	28%
Delaware	15%
Washington, D.C.	17%
Florida	26%
Idaho	56%
Maine	46%
Tennessee	22%
Texas	33%
Vermont	66%
Virginia	28%
Wyoming	48%

The new EPSDT regulations require that all eligible children over the age of three be referred to a dentist. There are as yet no published statistics to indicate current utilization rates by the eligible population. The ADA is, however, in the process of updating its 1978 survey. According to an ADA spokesman, preliminary findings indicate both that fewer children are eligible for Medicaid and that fewer children are receiving at least one dental service under the program. This would suggest that the new regulations have been ineffective in increasing rates of utilization.

Problems of implementation of the dental component of EPSDT arise in part from the unequal distribution of dental manpower. Many areas of the country simply lack a network of dentists and dental auxillaries who can perform dental assessments and deliver needed treatment. In 1976,

the Manpower Analysis branch of the Public Health Service designated 777 counties designated as areas with critical dental shortages, nearly as many as the 894 counties designated as areas with critical medical shortages. (29) Under the new regulations, stemming from the Health Manpower Act of 1968, some 1,500 dental shortage areas are anticipated to be designated by DHHS. (159) While criticism has been leveled at the criteria used to make such designations (most often dentist-or physician-to-population ratios or number of dental visits per person per year), such ratios and counts do highlight broad variations by region and place of residence. (See Table 5). (187)

Attempts to define a "critical ratio" as a minimum level below which the supply of dentists (or physicians) is inadequate have been attacked as arbitrary, since the ratio assumes that both demand for and supply of dental services are constant and directly proportional to the population and number of dentists. As D. Born argues, "Demand . . . is known to vary with age, sex, race, income, floridation, and previous treatment. . . . Supply is known to vary by dentist's age, practice style, practice specialization, level of utilization of auxiliaries and age of dental equipment." (162) The ADA is seeking to develop a dental manpower policy model based on supply and demand indices to replace the dentist/population ratios presently used for dental health manpower planning decisions. (159) Problems of distribution have been explored much more extensively for physicians than for dentists. However, several studies document the tendency of dentists (like physicians) to concentrate in relatively affluent, metropolitan and urban areas, usually to the disadvantage of rural and inner-city areas, where most of the Medicaid-eligible population live. (162, 168, 175, 192)

Table 5

PERSONS-PER-DENTIST RATIOS, BY GEOGRAPHIC REGION AND PLACE OF RESIDENCE, RELATED TO DENTAL VISITS

Geographic area	Average persons-per-dentist ratio in 1977	Dental visits, 1969-1971: Percent of persons with dental visits within a year	Dental visits, 1969-1971: Average number of dental visits per person per year
United States	1,905	46.3	1.5
Geographic region			
Northeast	1,562	51.2	1.9
West	1,595	48.1	1.8
North Central	2,053	47.4	1.4
South	2,396	40.5	1.2
Place of residence			
Metropolitan areas	1,701	49.4	1.8
Non-metropolitan areas:			
Non-farm	2,575	43.1	1.2
Rural	3,664	41.9	0.9

SOURCE: Health Resources Administration, Bureau of Health Manpower, Division of Dentistry, based on unpublished 1977 data from the American Dental Association, Bureau of Economic Research and Statistics, and on data from National Center for Health Statistics, State Estimates of Disability and Utilization of Medical Services: United States, 1969-71; DHEW Publication No. (HRA) 77-1241, January 1977.

Since dentists do not locate in low-income areas, the poor in need of dental services must travel out of their neighborhoods in order to receive care. (172) This poses a major problem for rural and inner-city poor alike, who often cannot afford a means of transportation. Problems of access are multiplied since it is usually necessary to make a series of visits to a dentist over a period of several months to complete a program of care. The shortage of dentists in many areas also leads to long waiting periods for appointments. In Oktibbeha County, Mississippi, for example, EPSDT children often wait six months for a dental appointment. (29) All of these factors increase the likelihood that Medicaid patients will miss appointments, to the annoyance of participating dentists who are not reimbursed for "no-shows."

The Guide to Dental Care: EPSDT-Medicaid includes numerous "case studies in administration" to illustrate various ways of overcoming these barriers to access. To remedy the problem of transportation, a community may elect to enter into an agreement with the local school system for the provision of a driver and a school bus to transport children to and from the dentist. In rural areas or small communities lacking dentists, children may have to be bused in groups to another community. Children in underserved rural and inner-city areas can also be served by mobile dental clinics staffed by salaried dentists, who may be recruited through the National Health Service Corps, or who may be just setting up practices. They can also be served by dental clinics set up in neighborhood health centers staffed by part-time dentists paid on an hourly basis. (191)

But the failure of the dental component of EPSDT has more serious causes than the inadequacy of screening procedures and the maldistribution of dental manpower. It owes much to the special characteristics of the dental care delivery system itself. Most dentists engage in private solo practice on a fee-for-service basis. While other modes of delivery do exist, in public clinics, the National Health Service Corps, the Indian Health Service, the military services, and the Veterans' Administration, very few dentists are willing to practice in such settings.

As we have seen, the EPSDT program since its inception has had difficulty recruiting private providers. Many states have not been able to recruit enough private physicians to deliver the necessary levels of service under the medical component of the program. The problem has been even more acute in the provision of dental services, because the percentage of dentists willing to practice in public health settings and to treat Medicaid patients in their private practices is even lower than for the physician population.

Data on participation by dentists in EPSDT is scarce and subject to the same problems of interpretation as data on participation by physicians. However, EPSDT: THE POSSIBLE DREAM quotes a 1978 HEW study that estimates that nationally only 41 percent of dentists are participating Medicaid providers as compared to about 50 percent of physicians. Since even one Medicaid billing is often enough to designate a provider as "participating," the percentage of significantly participating dentists is probably even lower. (29)

During a 1978 conference on "Dentistry in the Medicaid Program," Sonken, a DHEW dental advisor, observed that:

> An average of only 40% of practicing dentists across the country are estimated to be participating in Medicaid to some degree. If I were to change that wording to say "significant participation," however, I would have to lower that estimate to about 10 to 15%. (158)

Ohio state senator Kenneth Cox reported during the same conference that "although Ohio has presently 3,098 dentists with provider agreements, more than 60% of these providers do not participate or have dropped out of the program. Several years ago when the program first started we had 5,913 dentists that signed provider agreements. I have also been told [that] of all the dollars paid out annually for dental services under the Medicaid program [in Ohio], between 50 to 60 dentists out of the 3,098 collect over one half of the Medicaid dollars." (158)

In August 1978 the American Dental Association surveyed state dental societies to ascertain what percent of dentists participate "significantly" in the Medicaid program. ("Significantly," it should be noted, was not defined either in terms of percentage of patient load or number of claims submitted. Thus the responses to this part of the ADA survey are necessarily subjective.) Thirty-four societies responded, reporting significant participation by between 11 percent and 92 percent of state-certified dentists, according to the distribution shown on Table 6:

TABLE 6

PERCENTAGE OF DENTISTS WHO PARTICIPATE SIGNIFICANTLY IN MEDICAID

State	% of Dentists Who Participate Significantly
Alabama	20%
Alaska	85%
Arkansas	90%
California	85%
Colorado	28%
Connecticut	20%
Washington, D.C.	23%
Florida	50%
Hawaii	85-90%
Idaho	80%
Illinois	50%
Indiana	65-75%
Iowa	90-95%
Kentucky	67%
Louisiana	40%
Maryland	43%
Massachusetts	20%
Michigan	53%
Mississippi	51%
Missouri	20%
Nebraska	90%
Nevada	70%
New Hampshire	26%
New Jersey	10%
New Mexico	41%
New York	20%
North Carolina	30%
Oklahoma	70%
South Carolina	30%
South Dakota	33%
Tennessee	50%
Texas	25%
Virginia	23%
West Virginia	25%
Wyoming	75%

BARRIERS TO PARTICIPATION

As in the case of physicians, there are many reasons for low rates of participation. The ADA survey of constituent societies reported the following barriers in descending order of importance:

Reasons that more dentists do not regularly treat patients under Medicaid	Percent of Societies
Inadequate fee schedule	34.0%
Administrative difficulties*	28.7%
Cancelled or broken appointments	17.0%
Benefit limitations	7.4%
Lack of recipient cooperation/utilization	5.3%
Delays in processing of claims	4.3%
Alternate treatment problems	1.1%
Increased office overhead	1.1%
Government encroachment in the private sector	1.1%

*Includes code systems, federal/state participation agreements, excessive paperwork, complicated claim filing, prior authorization, fluctuating eligibility, and communication problems. (157)

These barriers fall into categories similar to those outlined earlier for physicians:

- Financial disincentives and professional costs
- Loss of professional autonomy
- Anti-Medicaid sentiment

Financial Disincentives and Professional Costs

As a percentage of the total Medicaid budget, expenditures for dental care account for slightly less than 3%. (158) With the exception of the EPSDT Program, which is a mandate service, dental care is an optional service that not all states chose to provide. According to the ADA survey as of January 1979, 37 states indicated that dental benefits are available to the entire Medicaid-eligible population, including adults and children. (See Table 7) In six of these states (Georgia, Maryland, Mississippi, Nevada, New Hampshire and South Dakota) adult dental benefits are limited to emergency treatment. Among the remaining 31 states, 20 offer the same dental benefits to adults and children, while in 11 states the type of service that is covered is based upon the age of the recipient. In the 13 remaining states (Alabama, Alaska, Colorado, Delaware, District of Columbia, Florida, Idaho, Maine, Tennessee, Texas, Vermont, Virginia and Wyoming), dental benefits are offered only to children under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program. (In Alabama, Maine, Vermont and Virginia, covered services for adults cannot be termed dental benefits as such, but only medically-related dental services as allowed under Medicare, i.e. surgery and treatment of fractures related to the jaw or any structure contiguous to the jaw.) (157)

As a result of the optional status of dental benefits under Medicaid, dentists are in "a very tenuous position." In the words of Dr. Willging, recently appointed Deputy Administrator, Health

PROFILE OF STATE PLANS

e = Estimate
NA = Not applicable
NR = No response
1977 figures
1978 figures

State	Dental benefits available to:		Same dental services for adults and children	Number of persons eligible for Medicaid		Number of persons who have received at least one dental service		Total dollar amount paid for dental claims	Average cost per dental claim	Average cost per recipient of dental benefits
	Adults and Children	Children only under EPSDT		Adults	Children	Adults	Children			
Alabama		X	NA	185,894	145,997	662	40,740	$ 3,538,844	$ 42.00	$ 85.48
Alaska		X	NA	NR	NR	NR	NR	NR	NR	NR
Arizona[1]										
Arkansas	X		no	141,878	83,281	16,202	21,633	3,432,142	139.73	205.48
California	X		yes	Total of	2,767,480	647,143	445,459	105,299,000	69.25	72.30
Colorado		X	NA	NR	66,000e	NA	NR	1,651,572	60.00	NR
Connecticut	X		yes	99,144	139,816	NR	NR	3,566,000	41.49	NR
Delaware		X	NA	15,986	22,632	NA	3,291	240,243	73.00	73.00
D.C.		X	NA	48,420	84,675	NA	14,596	1,145,495	17.07	78.48
Florida		X	NA	400,955	196,260	NA	51,226	3,874,694	33.02	75.64
Georgia[2]	X*		no	248,036	158,650	NA	58,373	7,712,956	80.79	134.79
Hawaii	X		yes	Total of	96,052	24,982	25,737	8,268,054	94.49	163.00
Idaho		X	NA	15,820	13,330	NA	7,461	685,083	NR	72.31
Illinois	X		yes	380,316	515,820	NR	NR	26,698,435	NR	28.00
Indiana	X		yes	159,629	43,419	Total of	63,695	4,959,541	NR	77.86
Iowa	X		yes	96,909	111,855	23,461	34,264	5,511,630	56.49	95.44
Kansas	X		no	79,007	82,305	Total of	69,773	2,944,607	33.83	52.53
Kentucky	X		no	173,979	186,835	Total of	91,217	5,665,224	NR	62.11

[1]Arizona has not implemented a Medicaid program
[2]Adult dental emergency program added in July 1978
*Adult dental benefits are limited to emergency treatment

Table 7 (cont.)
PROFILE OF STATE PLANS

e = Estimate
NA = Not applicable
NR = No response
1977 figures
1978 figures

State	Dental benefits available to: Adults and Children	Dental benefits available to: Children only under EPSDT	Same dental services for adults and children	Number of persons eligible for Medicaid: Adults	Number of persons eligible for Medicaid: Children	Number of persons who have received at least one dental service: Adults	Number of persons who have received at least one dental service: Children	Total dollar amount paid for dental claims	Average cost per dental claim	Average cost per recipient of dental benefits
Louisiana	X[3]		no	199,977	169,955	NA	43,925	$ 4,042,372	$ 92.00	$ 92.03
Maine		X	NA	70,033	53,533	7,030	24,445	1,794,737	14.69	57.02
Maryland	X*		no	195,713	210,212	25,966	55,977	4,852,090	30.96	59.21
Massachusetts	X		no	NR	NR	NR	NR	NR	NR	NR
Michigan	X		no	337,331	477,004	51,148	150,408	20,140,471	16.12	99.92
Minnesota	X		yes	104,716	90,785	NR	NR	10,867,138	57.26	NR
Mississippi	X*		no	149,378	122,018	NR	NR	4,136,222	42.66	NR
Missouri	X		yes	NR	NR	NR	NR	NR	NR	NR
Montana	X		yes	33,742	34,610	5,188	6,817	1,524,721	NR	126.86
Nebraska	X		yes	30,766	26,217	7,024	8,990	1,461,797	73.78	77.79
Nevada	X*		no	NR	NR	1,116	1,609	303,955	50.00	111.50
New Hampshire	X*		no	51,300	25,500	1,798	9,486	716,121	36.30	63.46
New Jersey	X		yes	251,011	384,312	67,002	119,416	17,681,428	58.49	94.85
New Mexico	X		yes	Total of	82,073	Total of	13,759	1,516,709	41.00	110.00
New York	X		no	1,000,000e	1,200,000e	NR	NR	42,693,071	NR	NR
North Carolina	X[4]		yes	168,589	149,504	36,619	38,221	9,664,081	76.00	129.00
North Dakota	X		yes	14,421	11,441	3,542	5,385	1,272,643	20.26	85.14
Ohio	X		yes	Total of	678,959	67,312	104,200	10,925,621	NR	63.70
Oklahoma	X		no	82,871	61,695	3,510	20,459	2,334,794	NR	97.41

*Adult dental benefits are limited to emergency treatment

[3] An adult dental program began in January 1979
[4] The adult dental program was reinstated in July 1978

Table 7 (cont.)
PROFILE OF STATE PLANS

e = Estimate
NA = Not applicable
NR = No response
1977 figures
1978 figures

State	Dental benefits available to: Adults and Children	Dental benefits available to: Children only under EPSDT	Same dental services for adults and children	Number of persons eligible for Medicaid: Adults	Number of persons eligible for Medicaid: Children	Number of persons who have received at least one dental service: Adults	Number of persons who have received at least one dental service: Children	Total dollar amount paid for dental claims	Average cost per dental claim	Average cost per recipient of dental benefits
Oregon	X		yes	Total of	166,954	Total of	43,403	4,749,770	51.60	109.43
Pennsylvania	X		yes	1,010,000e	614,304e	209,376	195,256	18,078,819	28.86	44.68
Rhode Island	X		yes	46,213	40,955	Total of	20,684	2,729,990	24.29	131.98
South Carolina	X		no	61,732	113,028	NR	NR	NR	NR	NR
South Dakota	X*		no	17,963	18,183	-0-	5,454	361,578	54.70	86.30
Tennessee		X	NA	240,000	180,000	NA	40,000	3,200,000	NR	80.00
Texas[5]		X	NA	378,859	240,507	12,000e	79,000e	13,620,152	NR	149.67
Utah	X		no	Total of	48,360	8,709	15,754	2,131,913	69.14	78.04
Vermont		X	NA	21,701	18,875	601	12,485	1,095,530	32.45	84.36
Virginia		X	NA	183,934	183,500	875	50,917	4,239,823	9.56	82.00
Washington	X		yes	NR	NR	NR	NR	NR	NR	NR
West Virginia	X		no	64,457	77,997	10,962	13,263	1,516,064	45.92	10.64
Wisconsin	X		yes	200,000	200,000	NR	NR	17,000,000	49.53	36.17
Wyoming		X	NA	6,000e	4,500e	NA	2,171	263,952	75.52	75.52
TOTAL	37	13								

[5]The adult dental program was dropped in 1978
*Adult dental benefits are limited to emergency treatment

Care Financing Administration, "as far as the Medicaid legislative structure is concerned, dentists have, if you will, a second class program." (158)

Since dental services occupy a position of low priority in state Medicaid programs, they are among the first to be eliminated when expenses must be cut. One explanation for the inadequate levels of funding for dental services under Medicaid is to be found in the budget-making process itself: the Medicaid budget is not developed, reviewed, or evaluated on a line-item basis by Medicaid provider group. Although expenditure trend data are available by provider group, the Medicaid budget is developed in the aggregate by projecting inflationary trends in the medical sector and trends in service utilization and number of recipients. The process of establishing the Medicaid Budget thus tends to obscure program concerns of the optional service areas of Medicaid. (158) Dentists have difficulty getting a hearing. They are poorly represented on states' Medical Advisory Committees and see little chance, given the climate of cost containment, control of fraud and abuse, and Medicaid eligibility control programs, of receiving additional state funds to expand and improve the dental services component. (158)

In addition to the constraints imposed by limited funding, dentists point to low and untimely reimbursement as a major barrier to participation in Medicaid. Dentists in some states are reimbursed for their services at a lower rate than other health care providers. In 1975 the Ohio Dental Association sued the Ohio Department of Public Welfare in protest against this dual system of reimbursement, which denied dentists

equal protection of the law when compared to other health care providers. In mid 1978, while the case was still before the courts, dentists were being reimbursed according to a fixed fee schedule established in 1966, with no adjustments for inflation. Reimbursement levels represented only the 10th percentile of dentists' usual and customary fees. By contrast, other providers were being reimbursed up to the 75th percentile of their usual and customary fees. Similarly, Illinois dentists in 1978 complained of receiving only 50 percent of their usual fees. Their most recent increase had occurred in 1972 and had been "minuscule." Thus dentists feel they are "subsidizing" the Medicaid program. (158)

Delays in reimbursement and lack of reimbursement for services remain serious issues. Because treatment for dental problems often requires several appointments over extended periods of time, dentists are more susceptible than physicians to the problems of missed appointments and fluctuations in eligibility. Dentists receive no reimbursement for "no-shows." And changes in eligibility over the time needed to complete treatment lead to delays in or even lack of reimbursement. Rejection of claims adds to the administrative cost of participating dentists. State EPSDT/Medicaid programs may not include coverage of services that require long term continuity of care such as periodontics or orthodontics. While these limitations in coverage may protect dentists against non-reimbursable costs, at the same time they deny Medicaid children important benefits available to private-paying dental patients. (191)

Delays in processing routine claims, as opposed to claims complicated by problems of eligibility, are apparently not serious. According to the ADA survey, routine Medicaid claims were processed in an average of 30 days. (157)

Professional Autonomy

Dentists continue to recall the controversy over the dental screening component of the EPSDT program. From 1971 until 1979, dental screening was one component of the required screening package. The ADA argued that screening solely to determine if a child needs treatment was a waste. Furthermore, since the screening was not routinely performed by a dentist or dental hygienist, many children in need of dental services were not being referred for further diagnosis and treatment, as evidenced by previously-cited low rates of referral. The ADA advocated that screening should automatically be combined with diagnosis and initial treatment, including cleaning, topical fluoride application, and X-rays, without the requirement of prior authorization. Prior authorization should only be required for further treatment, such as repair of cavities.

The ADA Children's Defense Fund and other advocacy groups won support for this position. The regulations now require states to refer all children age three and older to a dentist for diagnosis and treatment. (30, 134)

The ADA has also argued for more flexibile authorization processes so that a dentist who discovers a previously-undetected problem while treating a patient can repair it immediately, without

having to seek further authorization and set up another appointment. Overly-rigid authorization procedures have been a major barrier to provider participation in some states. (57) Providers claim that this control subverts professional prerogatives with respect to treatment options, creates delays in treatment, and is expensive in terms of the professional time spent in preparing application forms and reviewing medical histories a second time in the case of application approvals. (56)

Anti-Medicaid Sentiment

The existence of anti-Medicaid sentiment among dentists, as among physicians, is another barrier to provider participation, although difficult to document. The Guide to Dental Care, prepared by the American Society of Dentistry for Children and the American Academy of Pedodontics, alludes generally to the problem:

> One of the major barriers in dental programs for a certain population group has been cultural and socioeconomic blocks to communication between the public assistance agency, the dentists, and the recipients of care. In some cases this represents primarily a difference in priorities, a lack of understanding of the basic premises under which the dentist operates, and of the premises held by families served by public welfare. In other instances, such as the Spanish-speaking population, there may additionally be a language barrier. (191)

The U.S. Department of Public Health, Division of Dentistry, has prepared a list of non-economic factors to explain the low utilization of dental services by the American public. Most of these are negative characteristics attributed to the non-utilizing public:

- ignorance of dental needs
- suspicion of innovative ideas

- low priority given to treatment
- fatalistic attitude of people towards dental care
- indifferent attitude towards dental care
- preference for folk medicine
- dentists supposed lack of humanistic concerns
- supposed racial prejudice of dentists, and
- hearsay about dentists' expertise (173)

Since the major "offenders" are the poor, non-white, less well-educated portions of the population, this list reveals much about the attitudes of some dentists toward the Medicaid population. As such, it provides some insight into reasons for low participation by dentists in Medicaid. Recent studies suggest, however, that public attitudes and beliefs about dental health and "oral health behavior" do not precede, but rather are formed by, experience and interactions with the health care system. If so, many of the negative dental health attitudes and apathetic behaviors attributed to the public must be explained by deficiencies in the current dental care delivery system, rather than by dental apathy and lack of motivation. (170, 173, 174)

A study by Frazier et.al. of provider expectations and consumer perceptions of the importance and value of dental care showed that providers tend to stereotype poor consumers and believe that they do not value dental services. In a study involving both dentists and welfare mothers, dentists consistently underestimated the importance placed by welfare mothers on good dental care. Dentists' comments revealed not only a failure to understand the clients'

attitudes but also a condemnatory attitude toward lower-class patients in general. Rejecting poor consumers' complaints that they cannot afford dental care, dentists observed that:

> Usually their priorities are for other things that fall in the luxury class.
>
> They don't want to 'afford it'. . .The people who can't 'afford' dental care can afford beer, snowmobiles, boats--even beauty shops and tailors--to go with their 'Black Jack' smiles.
>
> People of America in this bracket buy what they want and beg for what they need. (170)

This study cites other sociological investigations by Sherlock and Pavalko that examine factors influencing the interaction between health professionals and lower class clients. These studies indicate that members of highly striving occupational groups are significantly more negative in their orientations toward the poor or lower class client.

The tradition of dentistry has been to recruit upwardly mobile individuals and historically, dentistry has drawn recruits largely from non-professional, non-white collar backgrounds. (194, 195) According to a study by Walsh and Elling, a concern for professional prestige may deter many dentists from participating in Medicaid: a higher status is accorded dentists who serve an upper- and middle-class clientele while a stigma is attached to dentists who serve the poor. (197) An Illinois dentist speaking at the Conference on "Dentistry in the Medicaid Program," observed that one of the major barriers to participation by dentists in the Medicaid program was the attitude of the dental profession toward welfare dentistry:

> Welfare dentists traditionally have been considered second class citizens, poor brothers. We are generally looked down upon by the carriage trade dentists who oftentimes comprise the majority of our Dental Society officials. Oftentimes it is stated that the public aid dentistry problems are "not worth the effort." (158)

Another major barrier was the nature of the "public aid patient:"

> These poor people are the losers of Society. They are the sick, the aged, the disabled, the orphaned, people down on luck, the untrained, the poorly educated, the people who have language problems. They are poor job material, they are disorganized, they go by a crises philosophy and thus in our practices we see more diseases than in the average private patient. These people have difficulty keeping appointments. They are unreliable on taking their medications and following instructions. In essence, the public aid patient takes more time and effort to treat than would his private patient cousin. (158)

INCENTIVES TO PARTICIPATION

Those states that boast of a successful EPSDT dental services program and high participation by dentists attribute their success to the same factors cited earlier in the case of physicians. In Alabama, "communication, cooperation, and a desire to implement the program" on the part of both the dental professional organizations and state program officials were cited as the reasons for its success. The dental association was permitted input into the design of the dental portion of the state's program and many of its recommendations have been incorporated. (176) The Michigan Dental Association reported a similar pattern of success. (158) California's Denti-Cal program, administered jointly by the California Department of Health and the California Dental Service (a member of the nationwide Delta Dental Plans System) boasts of a highly successful dental program under Medicaid. While utilization data on Medicaid eligible children are

not broken out, utilization by the total eligible population stood at 40% in 1978. Denti-Cal also claimed a participation rate by dentists in excess of 90%. Success of the program was attributed to:

- Levels of reimbursement approximating dentists' usual and customary fees
- Elimination of most requirements for prior authorization, thereby reducing the "paper hassle" and the need for repeat appointments: dentists could in most cases examine a patient and provide routine and/or necessary services in one appointment
- Expansion of the benefit structure to emphasize preventive care and to cover treatment services available to private dental patients. (158)

Texas, in a 1977 report, claimed a 30% utilization rate by eligible children and participation rate by dentists of 43%. The Texas Dental Association attributed the program's relative success to a number of factors which it set forth as a series of "Guidelines" to be followed by State officials seeking to implement a successful EPSDT dental services component. These guidelines duplicate many of the important techniques or methods used to encourage physician participation in EPSDT. They are:

1. Input of the dental profession before the program goes into effect.
2. Continuing input into the program from a professional advisory committee.
3. The usual, customary, and reasonable fee basis.
4. The patient's freedom of choice of participating dentists.

5. Prompt reimbursement to dentists.
6. Simple forms to be completed.
7. Relatively few changes for the dentist and his staff to follow.
8. Administration of the program by dentists and not lay administrative staff because only dentists have genuine understanding of the needs of the participating dentists as well as the recipients of care.
9. Screening only when treatment and diagnosis is included at the initial visit.
10. Annual review of the dentists' fees for the past calendar year, as required in Title 45.
11. Provision that dentists must be able to treat all patients in their usual and customary manner.
12. Confidence and support of the professional organization and its members.
13. Provision for preventive services and oral health instruction because this is the only way to break the chain of recurrent problems and continued expense. (180)

SECTION VI

MARKETING

MARKETING AND THE HEALTH CARE INDUSTRY: AN OVERVIEW

An effective marketing methodology for provider recruitment must reflect the collective discoveries of past and present research in the general field of health care marketing. Accordingly, the literature review surveys issues and trends in this field. While some of the literature on health care marketing may not be directly relevant to the problem of physician recruitment, it does establish the context or environment in which recruitment efforts take place.

Marketing, as it applies to the health care industry, is a relatively recent phenomenon. It owes its emergence to a variety of factors. These include: the excess capacity of hospital beds, a result of over-building during the 60's; the new national emphasis on preventive health care which sets out to bring high-risk populations (the elderly, the poor) into the delivery system for routine periodic screening and diagnosis; the continued maldistribution of health manpower, despite the efforts during the 60's to produce more physicians; as well as the general growth of "consumerism," which demands that organization become more responsive to the needs and desires of consumers. (21, 31, 116) Robinson and Whittington summarize these and other factors in Table 8. (116) As Clarke comments, few health professionals now question the appropriateness of marketing as an essential management tool in the health care field. What they ask instead is; 1) "What exactly is marketing as applied to health care?", and 2) "How does one implement marketing in a health care organization?" (21)

TABLE 8

SOME REASONS FOR RISING LEVELS
OF INTEREST IN HEALTH CARE MARKETING

Reason	Explanation
1. Rising costs	With rapid escalation of health care costs has come a search for methods and techniques to slow the rate of increase. Marketing may be useful to health care administrators in effecting cost containment measures.
2. Rising accountability	Legislation has created mechanisms for review of health care service providers. Providers are now required to have information to support requests for additional services and to defend the allocation of resources. Marketing techniques and concepts are useful in the development of such information.
3. Trustees and directors have placed increasing emphasis on the health care consumer's needs	Administrators must demonstrate to governing boards that health care consumers have been consulted and their needs considered in planning and operating the services offered.
4. Increase in proprietary health care services	There have been widely reported successes of such profit-making health care services as hospital management firms, proprietary hospitals, health maintenance organizations, group practices, and emergency clinics. As a result, many health care organizations believe that they must become more competitive and devote increased attention to their principal markets.
5. Underutilization viewed as waste	Marketing provides the administration with concepts and techniques to smooth irregular demand patterns, to review consumer needs, to identify and reach target markets, and to measure customer satisfaction with services offered. Thus, marketing may be useful in increasing levels of utilization without creating demand for unneeded services.
6. Duplication of Services	Marketing can assist administrators to measure total demand, assess the level and quality of services offered by other health care providers, and determine which services should be offered to meet effectively the needs of the markets served by the organization. Thus, marketing can provide information to assist decision makers in their quest to achieve effective utilization of available financial, human and equipment resources.
7. Rising sense of professionalism by staff	Increasingly, nurses, pharmacists, respiratory therapists and other staff members seek recognition for their contributions. Marketing with its emphasis on exchange relationships with key publics, provides an approach to administrators faced with an increasingly complex set of staff needs and expectations.

TABLE 8 (cont'd)

Reason	Explanation
8. Changing nature of patient-physician relationship	Patients have become more active participants in decisions affecting their health care. Choices with respect to where, how, and what health care services are sought are influenced increasingly by consumer awareness and knowledge. Marketing techniques are useful in development of consumer awareness and in providing information about alternative services.
9. Rising interest in prevention	While most consumers still seek health care on an episodic, curative crisis basis, there is a clear trend toward utilization of preventive health services. Preventive health services possess characteristics that are amenable to marketing efforts, and that can reduce the overall costs of health care substantially.
10. Rising consumer dissatisfaction with health care	Expectation levels of health care consumers are rising. Therefore, health care providers must develop better understanding of consumer expectations and satisfaction levels. Marketing provides the measurement techniques needed to determine patient expectation and satisfaction.
11. Health care as a business	Many observers believe that health care possesses the elements of a business. That is, there are products and services that are offered to consumers by competitors at prices and locations that differ substantially. Effective public relations and promotional techniques also use the same principles as do business firms.

Robinson, Larry M., and F. Brown Whittington : "Marketing as Viewed by Hospital Administrators." In Health Care Marketing: Issues and Trends. London: Aspen Systems Corporation, 1979, pp.40-41.

The Marketing Concept

Current marketing theory works hard to dissociate "marketing" from its somewhat disreputable cousin "selling." Kotler formulated what have become classic definitions of "selling" and "marketing:"

"The selling concept is a management orientation that assumes that consumers will normally not buy enough of the company's products unless they are approached with a substantial selling and promotion effort." (81, p.13)

"The marketing concept is a customer orientation backed by integrated marketing aimed at generating customer satisfaction as the key to satisfying organizational goals." (81 , p. 15)

Central to marketing theory is the concept of "exchange," whereby two or more parties willingly engage in an exchange of goods, services, or other currencies, so that both parties are better off than before, or at least not worse off.

Marketing management, then, is:

> the analysis, planning, implementation and control of programs designed to bring about desired exchanges with target markets for the purpose of achieving organizational objectives. It relies heavily on designing the organization's offering in terms of the target market's needs and desires using effective pricing, communication, and distribution to inform, motivate and service the market. (81, p. 7)

Cooper modified this last definition to fit the health care field: "The marketing concept is a health system's management orientation that accepts that the key task of the system is to determine the wants, needs and values of a target market(s) and shape the system in such a manner to deliver the desired level of satisfaction." He goes on to quote a classic statement by Drucker, "The aim of marketing is to make selling superfluous. The aim of marketing is to know and understand the consumer so well that the product or service fits him and sells itself." (33)

The taint of "selling" still clings to the marketing concept in the minds of many health administrators. One need only recall the mixed professional response to the use of promotional advertising by hospitals, the publications of AHA Guidlines on Advertising by Hospitals (1977), and the AMA's debate on the ethics of physician solicitation. (11, 90) Thus, the adaptation of the marketing concept into the organizational hierarchy has been slow.
As Clarke and Garton point out, marketing has had no place on the curriculum of traditional degree programs for future health administrators, let alone on the medical school curriculum. And many key administrative posts are filled by physicians, whose professional background, with its traditional strictures against solicitation, might lead them to regard marketing as unethical. For these reasons, "there are few health care managers . . . with any training or background in marketing." (31)

Garton, however, notes that "while marketing as a discipline is new to the health care field, it has used marketing concepts for many years. All successful institutions have the pieces of a good marketing program, but they have not combined them into as effective a tool as possible. The growing literature on the subject of hospital marketing illustrates an active commitment by many administrators to forge new directions in health care marketing. (55, 69, 75, 89, 105, 107, 130)

A few larger and more prosperous hospitals have created positions of Vice President for Marketing. Smaller organizations have chosen other options: either to train existing personnel in marketing by means of seminars and conferences; to hire someone with marketing experience from outside the health care industry; to retain consultants with expertise in health care marketing on a interim basis; or to rely on professional schools to produce graduates with necessary marketing skills. (31)

The Role of Market Research

The role of marketing and market research in the planning process of the health care organization has also been misunderstood. Kotler, Clarke, Flexner, Brown and others emphasize that "market research," the analysis of consumer behavior and the environment or marketplace in which an organization functions, must occupy a position antecedent to the formulation of goals and objectives and strategies for implementation. Otherwise, the organization is not responding to the consumer's needs. But it is widely recognized that the current health care system is oriented toward the factors of production. Burger states that "the design of the system in terms of its product attributes, prices, messages, and channels of distribution are built to serve the doctors and administrators, with little concern for the effects on and the perception by the consuming public." (23) Brown similarly describes the health care system before marketing began to play a growing role in the planning process:

> The services were organized and provided in terms of what physicians and hospitals decided the community and patients should have, what physicians and hospitals wanted most to do and what best suited the aspirations of physicians and hospitals. . . The system set the specifications for its services and asked the community to fit those specifications. (21)

Many organizations that do include market research in their planning process incorporate it after rather than before the formulation of goals and strategies. (13) Administrators and doctors must overcome what Burger describes as their "marketing myopia" and give marketing a prominent role in the planning process. (23)

The Marketing Audit

An essential tool for any organization that plans to introduce a formal marketing component is the "marketing audit." The marketing audit is:

> a systematic, critical, and impartial review and appraisal of the total marketing operation: of the basic objectives and policies and the assumptions which underlie them as well as the methods, procedures, personnel, and organization employed to implement the policies and achieve the objectives. (13)

The audit serves many purposes, among which Berkowitz and Flexner single out these five:

- it appraises the total marketing operation
- it centers on the evaluation of objectives and policies and the assumptions that underlie them
- it aims for prognosis as well as diagnosis
- it searches for opportunities and means for exploiting them as well as for weaknesses and means for their elimination
- it practices preventive as well as curative marketing practices (13)

The audit should address a wide range of questions covering the organization's market and market segments; internal structure; history; competitive position; goals and objectives; strengths and weaknesses; products and services; pricing policies; promotional activities; and channels of distribution. The knowledge gained from an audit is vital to successful adaptation in a changing environment. See Attachment A for a complete audit. (13)

A key part of the marketing audit is developing predictive models of consumer behavior for the various target populations. While business organizations have a long history of behavioral research and have used their findings to reduce waste in developing and marketing new products, non-profit organizations in general and health care organizations in particular are only beginning to see the need for such research. (80, Cp.1)Burger reviews several attempts to formulate behavior models of health consumers (for example, the "Anderson Model Schematic" and the "Zaltman Model.") He then develops a comprehensive new "Model of Client Utilization Behavior" that encompasses such variables as: the consumer's perception of need, psychosocial variables,

economic variables, readiness to respond, health attitudes, health action, delivery service attitudes, and feedback. (23)

Tyson underscores the special problems that distinguish the "client utilization" behavior or "buying process" of health care services from models of consumer bahvior drawn from the business sector. Speaking specifically about hospitals, Tyson writes:

1. Not only is the "product" (treatment for illness) not really wanted by consumers, but its purchase is seldom planned because one can't predict appendicitis, pneumonia, heart attacks or kidney failure.

2. The hospital's "salesmen" (doctors) who bring in the "customers" (patients) are not employed by, controlled by or paid by the "company" (hospital).

3. Customers can't shop for "suppliers" (hospitals) in the conventional sense and find it difficult to make a price-value comparison of the products that are available.

4. Over 70 percent of the "company's" (hospital's) customers do not pay for the product themselves; rather payment is made by "third parties" (Blue Cross, Medicare, etc.) who do not use the product - but tell the hospital how much they will pay, when they will pay and under what conditions they will pay. (130)

Similarly, in the area of preventive health care, Hochbaum distinguishes the "product" to be marketed ("health actions"), from the typical commerical product that is produced in response to consumer need and demand:

> In contrast, the health actions on which we try to "sell" the public are given to us. They are prescribed by the medical and other health professions. And these prescribed . . . health practices are defined rather exactly and inflexibly. They can rarely . . . be tailored to consumers' desires, motives or preferences. Instead of offering our consumers things they like and want, almost all the things we offer then in the health area, especially in preventive health, are inherently unpleasant, inconvenient, humiliating, and painful; they disrupt old, accustomed living habits; and they necessitate depriving oneself of things one wants and enjoys. Moreover, there is precious little we can do to fit the product to the consumer's tastes or to package it attractively. (64)

Marketing Public Health Programs

Officials of public health programs in general and the EPSDT program in particular, charged with the responsibility of marketing a preventive health program to the poor, are up against particularly difficult problems. The inherent disincentives to "consumption" of preventive health care are compounded by the special characteristics of the diverse client population served by EPSDT; urban poor, rural poor and various racial and ethnic groups. Each group has a different set of needs and expectations and must be approached by different marketing strategies. The needs and behavioral characteristics of the EPSDT client-consumer have received great attention, both in planning and in implementing the program. The screening program was designed in response to statistical evidence on the incidence of disease among the poor and in accordance with accepted theories about the value of preventive health care. Marketing EPSDT to eligible clients, usually referred to as "outreach" and "case finding" has also received much thought. It is not the purpose of this review to provide an enhaustive list of EPSDT "outreach" materials. In general, most "how-to" booklets on the EPSDT program include a section on outreach. (144,147,151,152) DHEW funded a training manual Marketing EPSDT to Clients, devoted entirely to the subject. Most assessments of state programs evaluate the outreach methods used and make recommendations for their improvement. (145)

Marketing and Physician Recruitment

While the concept of "outreach" to clients is quite familiar, the concept of marketing to physicians is relatively new, as the paucity of literature indicates. Marketing a public health program like EPSDT to physicians

is in many ways analogous to marketing preventive health care to the general consumer: many physicians, like health care consumers, resist a program that offers few immediate rewards or incentives to participate, disrupts established practice routines, and is prescribed by "outsiders" who do not understand the physicians' perspective. Only a few studies, previously cited in this review, begin to address the problem of physician recruitment from a marketing perspective. (25, 131, 137)

Not surprisingly hospitals are in the forefront of marketing to physicians, having for some time recognized that physicians constitute yet another "public" that must be cultivated. Because hospitals rely heavily on medical staff to draw patients, marketing to physicians, in a period of rising costs and empty beds, has become a serious matter, even to the more prosperous and well-situated hospitals. As O'Hallaron, Staples and Chiampa demonstrate, hospitals use a variety of incentives to recruit physicians:

> It is common for a hospital to grant privileges to physicians who have similar rights in three or four other hospitals in the vicinity. The hospital then finds itself very much in competition with other hospitals for the favor of these physicians. Many hospitals today are attempting to solve this problem by developing an office building for physicians adjacent to the hospital. Providing special equipment, such as gamma cameras, cardiac diagnostic services, nuclear medicine, ultrasound, radiation therapy, and special care facilities, is another means used to lure physicians to a particular institution. The marketing director could serve as consultant to both a medical director and an administrator in determining what new services should be offered both to attract doctors to the hospital and to increase the utilization of the hospital's personnel and facilities. Developing an environment in which "a doctor wants to practice" is a highly important goal which requires sensitivity and coordination to achieve. (107)

Kotler also notes that more hospitals are providing "ego services," such as saunas, tennis courts, chauffeur service. (90)

Inner city and rural hospitals face more serious problems. With the recent legislation limiting the number of Foreign Medical Graduates that any

single hospital can employ, inner city hospitals in particular are under great pressure to develop new incentive structures to entice American physicians to serve on their staff. This problem was the subject of a recent conference, which produced a report reviewing possible alternatives: Invitational Conference on the Delivery of Health Care in Urban Underserved Areas. Another new study by Olson addresses this problem, Physician Recruitment and the Hospital (not yet available). (76, 108)

A marketing approach to physician recruitment requires a knowledge of the needs and values of the physician-consumer. There has, however, been little systematic behavioral research on different segments of the physician population. Any attempt to explain physician behavior should begin with an economic analysis of the service market in which he operates. The complexity of this market has caused some critics to question the somewhat simplistic equation of low reimbursement-low participation, high reimbursement- high participation to explain provider participation in programs serving the poor. The theory of price discrimination, as discussed earlier, assumes that physicians operate within a competitive market. A competitive market is characterized by:

a) many firms, each of which controls so small a proportion of total output that its addition to or removal from the market has little or no effect on the market price;

b) homogeneity of products - i.e., all firms must be known by buyers to produce identical products;

c) freedom of entry and exit;

d) independent decision making, with no collusion. (12)

Other economists suggest that perfect competition also is characterized by:

e) perfect knowledge which (minimally) includes knowledge on the part of consumers, producers, and resource owners with respect to prices, wages, costs and other relevant information. (143 , p. 25)

But the physician service market varies considerably from the competitive market. The physician market is characterized by:

a) product heterogeneity - each product (physician service) is unique. The content and quality, as perceived by the patient, is dependent on that physician's style, attitude and personality, rather than the technical aspects of care;

b) Restriction on entry - state licensing board and professional associations control entry into the medical market place and control the organizations within which the physician practices (such as the AMA's long opposition to prepaid group practice). (43, 46, 77, 113)

c) Imperfect knowledge - There is a great difference between the patient's knowledge and the physician's concerning medical services. Thus, the patient is unable to compare alternative services and procedures. Moreover, until this year, the American Medical Association has barred physician advertising, the most common method used in most industries to impart information to consumers.

Rather empirical evidence suggests that physicians operate within a more oligopolistic market, i.e., that they can determine their fees with a wide degree of discretion. (122) Physician trade journals describe techniques for setting fees that pay no attention to market factors. (59, 129) Yet physicians have historically discounted their fees or provided "charity" cases for poor people. This capability to charge different fees to different patients is another example of monopoly power. (77, 92, 125)

The "doctor-patient" relationship or "trust" relationship, when the doctor is assumed to use his special knowledge in the best interest of his patients is another cornerstone in the explanation of physician motivation. (10) The Hypocratic Oath and medical ethics take precedence over patient wishes. This coupled with acceptance of discounting fees suggests that profit maximazation does not singularly motivate physician behavior. Physicians do weigh factors other than income or profits when they set fees or make other practice-related decisions.

Some researchers have concluded that "satisficing" - establishing income targets - may more closely explain physician behavior. (45, 103, 104)

The Medicaid fee is only one of many considerations that go into a physician's decision to serve Medicaid clients.

Problems associated with Medicaid fees are likely to have different effects on the behavior of physicians who have large numbers of Medicaid clients and those who have very few. (65) Since the marginal cost of producing most ambulatory care declines as output increases, the physician with a relatively small number of Medicaid clients in their practice may still find that fees exceed the marginal cost for most services. The physician with a large percentage of Medicaid clients may find low fees more detrimental to their income objectives. These physicians view services to Medicaid recipients not as charity; rather they expect renumeration to cover their total costs and contribute substantially to their financial well being. (65)

In addition to economic studies of the physician service market, there are other sources of information that can be assembled into physician profiles. As previously mentioned, the National Health Service Corps has done research on factors affecting practice location decisions, as well as on the type of medical school graduates that are inclined to serve in public health programs. (117, 153) The study Recruiting and Retaining Federal Physicians and Dentists: Problems and Progress identifies factors that deter physicians from practicing in remote and isolated areas: geographical isolation, cultural differences of isolated populations; social and cultural isolation; lack of professional activities; and lack of medical support services and educational and recreational activities. Inadequate income associated with rural or remote practice locations was also cited. (153)

Numerous other studies have sought to pinpoint the key factors which influence and motivate physicians to establish practices in specific locations. The Public Health Service, Bureau of Health Resources Development, compiled a useful bibliography of works published before 1974: Factors Influencing Practice Location of Professional Health Manpower: A Review of the Literature. (188) Population size is a key factor in determining physician location, as is per capita income. New physicians prefer to locate in high-income, urban communities that are experiencing population growth. (175) Availability of opportunities for professional advancement and medical support plays a major role in a physician's decision. Specialists, for example, are attracted to communities containing medical schools and an adequate number of hospital beds. Conversely, physicians in rural areas tend to be older General Practitioners with large practices and limited access to hospital facilities. As they retire or die, they are not being replaced. (169) Because of the great demand for their services, physicians, according to another study, assume that patients will come to them, regardless of where they decide to locate. They select locations that will save them travel time: near hospitals, in commercial districts, or on major arteries. An analysis of Chicago census tract data demonstrated clear-cut differences between primary care physicians and specialists: the former tended to shun inner city locations while most specialists tended to choose locations in central business districts or near hospitals. Primary care physicians preferred to locate in outlying census tracts and to provide services to nearby residents. Populations in middle-income areas did not always have physicians located in the vicinity. (44)

The marketing experience of the pharmaceutical industry adds an interesting perspective on the physician market: G.D. Searle segments the physician market largely according to physician speciality and age. The market is cultivated in several ways: advertising in medical journals and house journals of the specialty organizations, direct mailings, and personal sales by field representatives. According to industry-wide data (IMS, 1979), the promotional budget is allocated as follows: 23% on advertising, 5% on direct mailing and 71% on personal sales. The emphasis on personal sales corresponds with previously cited evidence that personal calls are the most effective technique for recruiting physicians for EPSDT.

Drawing on theories about the "diffusion of innovations" and the "consumer-adoption process," which categorize consumers according to the speed with which they adopt innovations, Searle's marketing specialists have discovered that young doctors fresh out of medical school tend to be "innovators" and "early adopters" while older doctors fall into the category of "late adopters" or "laggards." They also note that, depending on product type, there is a hierarchy by specialty in the adoption process. If the product is highly technical, specialists will try it first. If they find it acceptable, internists will try it; eventually, primary care practitioners will adopt it. If, on the other hand, the product is undifferentiated by specialty and non-technical, it will be adopted by primary care practitioners first and the adoption process will occur in reverse order. This latter type of product requires a higher level of promotion. (26, 71, 81, p.224F.)

One might reasonably expect to find similar patterns of adoption and resistance by age and specialty among physicians when confronted with a "new

product" like Medicaid or EPSDT. Physicians who received their medical training during the 60's when the tide of policial consciousness was running high and Medicaid became law, and the 70's, may demonstrate more willingness to serve the poor than older physicians for whom Medicaid represented a new threat to traditional practice models. Similarly, primary care practitioners can reasonably be expected to adopt a comprehensive "product" like EPSDT more readily than specialists. Preliminary findings of a 1980 assessment, "Availability of Physician Services to Medicaid Beneficiaries," support these hypotheses. (42) Although the Final Report is not yet available, the assessment outlines key characteristics of physicians who do and do not participate in Medicaid:

Those physicians most likely to serve Medicaid patients include:

- newly-established foreign born doctors (usually Filipinos or doctors with spanish surnames)
- doctors affiliated with medical schools and/or teaching hospitals
- primary care physicians
- doctors with practices located within low-income communities

Those physicians most likely not to serve Medicaid patients include:

- anglo physicians
- older doctors with well established practices
- specialists
- doctors in rural areas or those with small practices
- doctors located in high-income areas of town (42)

These findings are reinforced by the recent survey by the American Academy of Pediatrics which found that, in general, pediatricians participating in

Medicaid are younger than non-participants; have been practicing in the community for less time; and come from smaller communities. The survey goes on to identify the most promising target group for recruitment efforts aimed at increasing the level of provider participation in Medicaid: physicians with growing practicies who are already Medicaid-providers, but who limit the extent to which they accept Medicaid patients in response to certain problemmatical aspects of the Medicaid program. (1)

Other organizations that regard physicians as consumers are the providers of Continuing Medical Education (CME). Although the "tombstone announcement" (course, name, location, dates, topics, faculty, registration form) still serves as the basic promotional technique, CME providers are beginning to develop a marketing orientation toward the planning and promotion of their programs. Recent research by Richards and Cohen on why physicians participate in CME, summarized in the "CME Marketing Memo" for general use by providers, sheds some light on physicians' value systems:

REASONS FOR CME PARTICIPATION

Part of professionalism

- Personal motivation (internalized self-requirement)
- Documentation/legislative pressure

Interest in subject

- Keep up with field
- Combat obsolescence
- Practice relevance
- Intellectual curiosity

Validation of prior learning

- Evaluating, reorganizing, reinforcing prior knowledge/skills
- Reassurance
- Self-confidence
- Satisfy achievement-orientation

Attaining specific personal objectives

- Specific patient problems
- Learn about new procedure(s)/agent(s)
- Advancement preparation, e.g., boards, career changes
- Correct identified deficiencies

Change of pace

Relief from daily practice
Peer interaction
Social/recreational

Such data is intended to provide a basis for program planning and promotional communications. (79)

SECTION VII

SUMMARY

From a marketing perspective, the history of the EPSDT program illustrates what can happen when a "product" is designed without thorough attention to its intended "consumers." EPSDT planners assumed, erroneously, that the program had only one set of consumers--Medicaid eligible persons under the age of 21. The forgotten consumers in this case were the physicians and dentists. Since they were the providers, planners overlooked the fact that they were also consumers of the program and that levels of provider participation would be a major indicator of the program's success. Surprisingly little attention was paid to the needs of the provider-consumer. Physicians and dentists were not extensively consulted even when it came to establishing the content of the screening program, with the result that some of the mandated screening procedures were, in their opinion, unnecessary or obsolete. As the literature on provider participation and barriers and incentives to participation amply documents, the failure to consider this segment of consumers has seriously impeded the successful adaptation of the program. The recurrent complaints by providers about the lack of communication with EPSDT administrators and the lack of provider input in the planning process prove that their needs have been largely ignored. Now, officials recognize the necessity of marketing EPSDT to providers. Genuine marketing, as opposed to selling, inevitably requires some redesigning of the "product" to bring it more into line with expressed needs of the "consumers." Otherwise, there will remain little potential for "exchange " and officials will continue to find themselves faced with recruitment problems.

ATTACHMENT A

A MARKETING AUDIT

The Market and Market Segments

How large is the territory covered by your market? How have you determined this?

How is your market grouped?
- Is is scattered?
- How many important segments are there?
- How are these segments determined (demographic, service usage attitudinally?

Is the market entirely urban or is a fair proportion of it rural?

What percentage of your market uses third party payment?
- What are the attitudes and operations of third parties?
- Are they all equally profitable?

What are the effects of the following factors on your market?
- Age
- Income
- Occupation
- Increasing population
- Demographic Shifting
- Decreasing birthrate

What proportion of potential customers are familiar with your organization, services, programs?
- What is your image in the marketplace?
- What are the important components of your image?

The Organization

Short history of your organization:
- When and how was it organized?
- What has been the nature of its growth?
- How fast and far have its markets expanded?
  Where do your patients come from geographically?
- What is the basic policy of the organization? Is it on "health care" profit?
- What has been the financial history of the organization?
  -- How has it been capitalized?
  -- Have there been any account receivable problems?
  -- What is inventory investment?
- What has been the organization's success with the various services promoted?

The Organization (cont'd)

How does your organization compare with the industry?
- Is the total volume (gross revenue, utilization) increasing, decreasing?
- Have there been any fluctuations in revenue? If so, what were they due to?

What are the objectives and goals of the organization? How can they be expressed beyond the provision of "good health care"?

What are the organization's present strengths and weaknesses in:
- Medical facilities
- Management capabilities
- Medical staff
- Technical facilities
- Reputation
- Financial capabilities
- Image

What is the labor environment for your organization?
- For medical staff (nurses, physicians, etc.)?
- For support personnel?

How dependent is your organization upon conditions of other industries (third party payers)?

Are weaknesses being compensated for and strengths being used? How?

How are the following areas of your marketing function organized?
- Structure
- Manpower
- Reporting relationships
- Decision-making power

What kinds of external controls affect your organization?
- Local
- State
- Federal
- Self-regulatory

What are the trends in recent regulatory rulings?

Competitors

How many competitors are in your industry?
- How do you define your competitors?
- Has this number increased or decreased in the last four years?

Is competition on a price or nonprice basis?

What are the choices afforded patients?
- in services
- in payment

Competitors (cont'd)

What is your position in the market -- size and strength -- relative to competitors?

Products and Services

Complete a list of your organization's products and services, both present and proposed.

What are the general outstanding characteristics of each product or service?

What superiority or distinctiveness of products or services do you have as compared with competing organizations?

What is the total cost per service (in-use)? Is service over/under utilized?

What services are most heavily used? Why?
- What is the profile of patient/physician who use the service?
- Are there distinct groups of users?

What are your organization's policies regarding:
- Number and types of services to offer?
- Assessing needs for service addition/deletion?

History of products and services (complete for major products and services).
- How many did the organization originally have?
- How many have been added or dropped?
- What important changes have taken place in services during the last ten years?
- Has demand for the services increased or decreased?
- What are the most common complaints against the service?
- What services could be added to your organization that would make it more attractive to patients, medical staff, non-medical personnel?
- What are the strongest points of your services to patients, medical staff, non-medical personnel?
- Have you any other features that individualize your service or give you an advantage over competitors?

Price

What is the pricing strategy of the organization?
- Cost-plus
- Return on investment
- Stabilization

How are prices for services determined?
- How often are prices reviewed?
- What factors contribute to price increase/decrease?

Price (cont'd)

What have been the price trends in the past five years?

How are your pricing policies viewed by:
- patients
- physicians
- third party payers
- competitors
- regulators

Promotion

What is the purpose of the organization's present promotional activities (including advertising)?
- Protective
- Educational
- Search out new markets
- Develop all markets
- Establish a new service

Has this purpose undergone any change in recent years?

To whom has advertising appeal been largely directed?
- Donors
- Patients
  -- former or current
  -- prospective
- Physicians
  -- on staff
  -- potential

What media have been used?

Are the media still effective in reaching the intended audience?

What copy appeals have been notable in terms of response?

What methods have been used for measuring advertising effectiveness?

What is the role of public relations?
- Is it a separate function/department?
- What is the scope of responsibilities?

Channels of Distribution

What are the trends in distribution in the industry?
- What services are being performed on an outpatient basis?
- What services are being provided on an at-home basis?
- Are satellite facilities being used?

Channels of Distribution (cont'd)

What factors are considered in location decisions? When did you last evaluate present location?

What distributors do you deal with (e.g., medical supply houses, etc.)?

How large an inventory must you carry?

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